STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: 341 Jordan Lane Operating Company II d/b/a
Wethersfield Health Care Center
341 Jordan Lane
Wethersfield, CT 06103

CONSENT ORDER

WHEREAS, 341 Jordan Lane Operating Company II (hereinafter the "Licensee"), has been issued License No.2283 to operate a Chronic and Convalescent Nursing Home known as Wethersfield Health Care Center, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on August 13, 2004 and concluding on November 3, 2004 and an additional inspection commencing on March 15, 2005 and concluding on June 3, 2005; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated January 13, 2005 (Exhibit A – copy attached) and a violation letter dated June 9, 2005 (Exhibit AI – copy attached); and

WHERES, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Marianne Horn, its Section Chief, and the Licensee, acting herein and through ~~Warren Cole~~, its ~~Managing Member~~, MICHAEL SHERMAN, VICE PRESIDENT AND GENERAL COUNSEL hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order.
2. The INC shall serve for a minimum of six (6) months at the Facility unless the Department identifies through inspections that the continued presence of the INC is necessary to ensure substantial compliance with the provisions of the Regulations of Connecticut State Agencies or federal requirements (42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities). The INC shall be at the Facility forty (40) hours per week. The Department may, in its discretion, at any time, reduce or increase the hours of the INC and/or responsibilities, if, in the Department's view, the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order. The INC shall function in accordance with FLIS's INC Guidelines (Exhibit B – copy attached).
3. The INC shall conduct and submit to the Department an initial assessment of the Facility's regulatory compliance and identify areas requiring remediation within two (2) weeks of assumption of the position. The INC shall submit a weekly written report to the Department identifying the Facility's initiatives to comply with applicable federal and state statutes and regulations and the INC's assessment of the care and services provided to residents, subsequent recommendations made by the INC and the Facility's response to implementation of said recommendations. Copies of said reports shall be simultaneously provided to the Director of Nurses, Administrator, and Medical Director.
4. The INC's position shall be occupied and the duties of said INC shall be performed by a single individual unless otherwise approved by the Department. The INC shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts inclusive of holidays and weekends. The Consultant shall confer with the Facility's Administrator, Director of Nursing Services, and other staff as the Consultant deems appropriate concerning the assessment of nursing services and the Facility's compliance with federal and state statutes and regulations. The INC shall make recommendations to the Facility's Administrator and Director of Nursing

Services for improvement in the delivery of direct resident care in the Facility. The INC shall have a fiduciary responsibility to the Department. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination which, during the term of this Consent Order shall be binding on the Facility.

5. The INC shall have the responsibility for:
   i. Assessing, monitoring, and evaluating the delivery of direct resident care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in the area in which said staff member demonstrated a deficit. Records of said training shall be maintained by the Facility for review by the Department;
   ii. Recommending to the Department an increase in the INC's monitoring hours if unable to fulfill the responsibilities within the stipulated hours per week;
   iii. Assessing, monitoring, and evaluating the coordination of resident care and services delivered by the various health care professionals providing services within the Facility; and
   iv. Monitoring the implementation of the Facility's plan of correction submitted for the violation letters dated January 13, 2005 and June 9, 2005.
6. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
7. The INC, the Facility's Administrator, and the Director of Nursing Services shall meet with the Department every six (6) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the INC. Said meetings shall include discussions of issues related to the care and services provided in the Facility and compliance with applicable federal and state statutes and regulations.

8. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon their request.
9. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations. Examples of violations which may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in condition, and/or failure to provide care and treatment to residents identified with unstable health conditions, and/or failure to implement physician orders or plans of care. Determination of compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
10. The Director of Nursing Service/Assistant Director of Nursing Service shall conduct random unannounced visits to the Facility to assess care/services being provided. Said visits shall occur on holidays, weekends, and shall include all three (3) shifts. Documentation of observations relative to these visits shall be maintained and available for Department review, upon request.
11. The Licensee shall immediately notify the Department if the position(s) of Administrator, Director of Nurses, Assistant Director of Nurses, and/or Medical Director, the Infection Control Nurse, and/or MDS Coordinator become vacant due to resignations. The Administrator shall provide the Department with weekly reports pertaining to recruitment efforts for any of the previously identified positions.
12. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall each ensure compliance with the following:
    a. Sufficient nursing personnel are available to meet the needs of the residents;
    b. Residents are maintained, clean, comfortable and well groomed;

c. Resident treatments, therapies and medications are administered as prescribed by the physician and in accordance with each resident's comprehensive care plan;
d. Resident assessments are performed in a timely manner and accurately reflect the condition of the resident;
e. Each resident care plan is reviewed and revised to reflect the individual resident's problems, needs and goals, based upon the resident assessment and in accordance with Federal and State laws and regulations;
f. Nurse aide assignments accurately reflect resident needs;
g. Each resident's nutritional and hydration needs are assessed and monitored in accordance with their individual needs and plan of care; and
h. The personal physician or covering physician is notified in a timely manner of any significant changes in resident condition to include, but not be limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician is not responsive to the resident's needs or if the resident requires immediate care, then the Medical Director is notified.
i. Residents with catheters are provided appropriate care and care is provided by qualified staff.
j. Residents with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored.
k. Residents are assessed for smoking and adequate supervision is provided for those resident's who do smoke.
l. Residents are assessed for and as necessary, identified as a risk for elopement. Necessary supervision is provided to prevent elopement.
m. Necessary supervision and assistive devices are provided to prevent accidents.

13. Appointment of a free floating Nurse Supervisor on each shift whose primary responsibility is the assessment of residents and the care provided by nursing staff. Nurse Supervisors shall maintain a record of any resident related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Said records shall be made available to the Department upon request and shall be retained for a three (3) year period.
14. Nurse Supervisors shall be provided with the following:
    a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
    b. An inservice training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to resident and staff observations, interventions and staff remediation;
    c. Nurse Supervisors shall be supervised (includes reasonable on-site supervising as described below) and monitored by a representative of the Facility Administrative Staff, (e.g. Director of Nursing Service, Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and State and Federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
    d. Nurse Supervisors shall be responsible for ensuring that all care is provided to residents by all caregivers in accordance with individual comprehensive care plans.
15. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the facility to monitor the requirements of this Consent Order.
16. The Facility shall establish a Quality Assurance Program to review resident care issues inclusive of those identified in the January 13, 2005 violation letter issued by the Department. The members of the quality assurance program shall meet at least monthly to review and address the quality of care provided to residents and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director.

Minutes of said meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

17. The Licensee shall pay a monetary fine to the Department in the amount of eight thousand dollars ($8,000.00), which shall be payable by certified check to the Treasurer of the State of Connecticut and shall be posted to the Department within (2) weeks of the effective date of this Consent Order. Said check and any reports required by this document shall be directed to:

Donna Ortelle, R.N.,
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308
MS #12HSR
Hartford, CT 06134-0308

18. In accordance with Connecticut General Statutes Section 19a-494, the license of 341 Jordan Lane Operating Company II known as Wethersfield Health Care Center is place on probation for a period of two (2) years.
19. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
20. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
21. The terms of this Consent Order shall remain in effect for a period of two (2) years from the

effective date of this document unless otherwise specified in this document.

22. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

341 JORDAN LANE OPERATING COMPANY II, LLC

7/5/05
Date

By: Michael S. Sherman
~~Warren Cole, its Managing Member~~
MICHAEL SHERMAN, VICE PRESIDENT AND GENERAL COUNSEL

STATE OF New Jersey)

County of BERGEN) ss July 5, 2005

Personally appeared the above named Michael S. Sherman and made oath to the truth of the statements contained herein.

Sabiana Aristide
Notary Public, State of New Jersey
My Commission Expires November 17, 2009

My Commission Expires: _____
(If Notary Public)

Sabiana Aristide
Notary Public [X]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

7/07/05
Date

By: Marianne Horn
Marianne Horn, R.N., J.D., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT

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January 18, 2005

Drieu Connors, Administrator
Wethersfield Health Care Center
341 Jordan Lane
Wethersfield, CT 06103

Dear Administrator:

Unannounced visits were made to Wethersfield Health Care Center on August 13, September 8, October 31 and Novembe 2, and 3, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting a certificati inspection and monitoring visit and an investigation.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

An office conference has been scheduled for January 24, 2005 at 10:00 AM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

The purpose of the meeting is to discuss the issues identified during the inspection. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violation(s) to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibili y for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Cher Michaud RN SNC/RAC

Cher Michaud, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

CEM/RMB/jf

c: Director of Nurses
Medical Director
President

CT00003253

Phone (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: August 13, September 8, October 31 and November 1, 2, and 3, 2004

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. Based on observation and staff interview, the facility failed to post cost information. The findings include:
   a. Observations on all days of the survey 10/31/04, 11/01/04, 11/02/04, and 11/3/04, identified no posting of cost information for oxygen, rehabilitation and/or hairdressing services offered in the facility. Interview with the administrator on 11/03/04 at 10:15 AM., noted that hairdressing costs were given to residents in the admission packets but other costs for rehabilitation and oxygen services were not posted in the facility.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

2. Based on the clinical record review, interview and observation for 3 of 12 sampled residents (Resident #s 1, 5 and 12) who had a change in condition, the facility failed to notify the physician. The findings include:
   a. Resident #1's diagnosis include peripheral vascular disease, renal failure and diabetes. Observation of the resident on 10/31/04 at 10:35 AM identified that the resident had an open area on the left calf area and the bandage to area was dated 10/29/04. The open area had copious amounts of purulent drainage and odor noted. Interview with the charge nurse on 10/31/04 at 10:50 AM identified that she was putting a dry protective dressing on left calf area, the dressing had not been changed since 10/29/04 and was not aware if physician was notified of open area on left calf. The physician's orders and current treatment record failed to identify that a treatment was ordered for the resident's left calf area. Review of the clinical record failed to identify that the physician was notified of the area.
   b. Resident #5's diagnoses included Alzheimer's disease. An assessment dated 6/03/04 identified short and long-term memory deficits and moderately impaired decision-making abilities. A hospital discharge summary dated 7/14/04 identified Resident #5 was admitted to the hospital on 7/7/04 with a diagnosis of dehydration and acute renal failure. A care plan dated 7/14/04 identified poor oral intake with interventions that included to offer oral fluids frequently and to monitor intake and output. The July 2004 intake and output record identified that from 7/14/04 through 7/20/04 (six days) a daily fluid intake of 660 milliliters (ml) to 1020 ml was recorded. A nurse's note dated 7/21/04 at 1:30 PM noted Resident #5 was weak, lethargic and consumed a small amount of fluids. The physician was notified and directed to obtain laboratory values. A laboratory report dated 7/22/04 indicated a blood urea nitrogen (BUN) level of 50 mg/dl (normal value 7-17 mg/dl),

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

sodium level of 156 mg/dl (normal value 135-145 mg/dl) and a creatinine level of 1.9 mg/dl (normal value 0.7 - 1.2 mg/dl). The nurse's note dated 7/23/04 identified that Resident #5 was transferred to the hospital for an evaluation. The hospital discharge summary dated 7/23/04 identified an admission diagnosis of dehydration, hyponatremia and acute renal failure. Interview with the dietician on 11/02/04 at 11:15 AM identified the resident's estimated fluid needs to be between 1100 ml and 1300 ml a day. Review of the clinical record, facility documentation and interview with the unit manager on 11/02/04 at 10:40 AM failed to identify that the physician was notified of the decrease in oral intake until 7/21/04 at 5:00 PM.

c. Resident #12 had diagnoses that included Parkinson's Disease and dementia. A quarterly assessment dated 7/9/04 identified the resident was severely cognitively impaired and required extensive to total assistance with activities of daily living. Nurse's notes dated 7/27/04 at 6:00 AM identified the resident complained of pain on movement of the entire left upper extremity with a plan to update the physician. Further review of the nurse's notes dated 7/27/04 on the 7-3 shift identified that although the resident did not complain of pain, the physician was not notified of the resident's complaint of pain at 6 AM. Further review of the nurse's notes dated 7/27/04 at 10:00 PM identified the resident continued to complain of pain of the upper left extremity and had a bruise of the upper left arm. A Physician's order for an x-ray was obtained. On 7/30/04 at 2:10 AM the resident was transferred to the Emergency Room with a diagnosis of a left shoulder dislocation. Interview with the Director of Nurses (DNS) on 11/04/04 at 10:30 AM identified that the physician should have been notified when the resident's change in condition was first identified.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(L) and/or (k) Nurses Supervisor (2).

3. Based on observation and staff interview, the facility failed to post survey results in an accessible location and failed to include in the posting, results based on a complaint investigation. The findings include:
   a. Observation of the facility on 10/31/04, 11/01/04, 11/02/04 and 11/03/04 identified that survey results were posted behind the reception desk.
   b. Observation of the facility on 10/31/04, 11/01/04, 11/02/04 and 11/03/04 identified the survey results posted at the reception desk at the main entrance and the rehab entrance did not include results from the complaint investigation conducted since the last standard survey. Interview with the Administrator on 11/03/04 at 10:15

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

AM failed to identify evidence that the results of the complaint investigation were included in the survey posting.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

4. **Based on clinical record review, interviews and observation for one of five sample residents, (Resident #5) who utilized a restraint, the facility failed to complete an assessment, obtain consent and/or care plan for the use of the restraint. The findings include:**
   a. **Resident #5's diagnoses included Alzheimer's disease. A Minimum Data Set (MDS) dated 8/12/04 identified short and long-term memory deficits, moderately impaired decision making abilities and the absence of restraints. A physician order dated 8/24/04 directed to use a lap tray with a reminder belt in the wheelchair. Observation on 10/31/04, 11/1/04, 11/02/04 and 11/03/04 identified Resident #5 sitting in the wheelchair with a clip seat belt secured around the waist. The unit manager in an interview on 11/02/04 at 10:40 AM indicated the seatbelt was a restraint and the resident could not release it. Review of the clinical record with the unit manager on 11/02/04 at 10:40 AM failed to identify that a restraint assessment or consent for the use of the seatbelt was completed. Additionally, the care plan failed to reflect the use of the seatbelt or interventions to address its use.**

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (o) Medical Records (H) and/or (o) Medical Records (I).

5. Based on clinical record review and interview for 2 of 13 sampled residents (Resident #s 5 and 12) that had an incident, the facility failed to thoroughly investigate the incident. The findings include:
   a. Resident # 5's diagnoses included Alzheimer's disease. A Minimum Data Set (MDS) dated 8/12/04 identified shift and long term memory deficits, moderately impaired decision-making abilities and extensive to total dependence required for Activities of Daily Living (ADL). The care plan dated 10/18/04 identified a bruise on the right side of the forehead and a 10.0 centimeter (cm) by 5.0 cm bruise on the right breast. Facility documentation dated 10/18/04 identified that the 7:00 AM to 3:00 PM nurse aide found the areas and reported them to the charge nurse. The documentation indicated the 7:00 AM to 3:00 PM and 11:00 PM to 7:00 AM charge nurses were interviewed about the bruises. Review of the facility

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

investigation with the unit manager on 11/2/04 at 9:45 AM failed to identify that staff members who provided direct care to the resident prior to the 7:00 AM to 3:00 PM shift were interviewed about the bruise.

b. Resident #12 had diagnoses that included dementia. A significant change assessment dated 8/06/04 identified the resident was moderately cognitively impaired and required extensive assistance with activities of daily living. Facility documentation dated 10/11/04 identified that during evening care a bruise was noted on the left wrist and right abdomen. Further review identified documentation that the cause of the bruises was not thoroughly investigated.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (g) Reportable Events (6).

6. Based on 3 of 5 personnel files reviewed, the facility failed to follow their policy on screening of new hires. The findings include:
   a. Review of a personnel file identified that staff member #1 was hired on 8/5/04. Additionally, a criminal background check was not completed until 11/1/04 (12 weeks later).
   b. Review of a personnel file identified that staff member #2 was hired on 9/13/04. A criminal background check was not completed until 11/3/04 (7 weeks later).
   c. Review of a personnel file identified that staff member #3 was hired on 9/13/04. A criminal background check was not completed until 11/3/04 (7 weeks later). Review of the facility policy on abuse prevention identified that in order to prevent employment of individuals who have been convicted of abusing, neglecting or mistreating individuals in a health care related setting, the facility will investigate the past histories of the individuals considered for hire. Additionally, the facility will conduct a criminal background check.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

7. Based on clinical record review and interview for 1 of 12 residents (Resident # 8) that required assistance with toileting, the facility failed to provide care to maintain the resident's dignity. The findings include
   a. Resident #8's assessment dated 5/07/04 identified the resident with moderately impaired cognition and total dependence on staff for transfers and toilet use.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Nurse's notes dated 7/18/04 at 7:30 AM identified R#8 stated "a Nurse Aide (NA) was mad because there wasn't enough staff and took it out on me, she slapped my arm." Interview on 11/2/04 at 10 AM with R#8 identified that she asked a nurse aide to assist her in using the bathroom and the NA said no and slapped her on the arm. She further stated she never got to use the bathroom and soiled her bed. Interview with the charge nurse on 11/03/04 at 10 AM identified the resident reported the incident to her on the beginning of shift and she reported it to her supervisor. Interview with the Assistant Director of Nursing, who at the time of the incident was the supervisor on 11/03/04 at 10:45 AM identified that when the incident was reported to her, she started the investigation. She further stated that when a resident needs care provided, the staff members are to assist the resident.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D).

8. Based on clinical record review, observation and interview for 1 of 6 residents (Resident # 25) who smoked the facility failed to meet the resident's needs. The findings include:
   a. Resident #25's diagnoses included depression. A significant change assessment dated 9/03/04 identified the resident with moderately impaired cognition and required limited assistance with Activities of Daily Living (ADL). The resident care plan dated 11/01/04 identified the resident as a supervised smoker. Interventions included to take the resident out to smoke per the smoking schedule. Observation on 11/01/04 at 11:15 AM identified Resident #25 approached this surveyor at the D-Wing nursing station, and asked in a loud voice to have a smoke. During this time, 3 staff members were noted to be standing at the nurse's station, however they did not respond to the resident. The resident was observed to leave the desk and ask another staff person about smoking and was told everyone was busy because the State was in the building and that she would have to wait. Interview with the unit manager at 11:45 AM identified that usually we find someone to go out with the resident. She further stated that although there was scheduled times for smoking she did not believe there was anyone assigned.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or (m) Nursing Staff (2)(A).

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

9. Based on observation and staff interview, the facility failed to maintain resident lounge areas on A, B, C and D wings and AB dining room areas in a clean comfortable manner. The findings include:
   a. Observation of resident lounges and dining rooms on 11/03/04 and 11/04/04 identified the following:
      i. A Wing lounge had side rail pads on the floor behind the television.
      ii. A Wing lounge contained two feeding tables, two straight chairs five boxes stacked and three locked file cabinets.
      iii. B Wing lounge contained a bed mattress and a large blue floor mat.
      iv. The C Wing Mary Steward Lounge contained three wheel chairs, one customized wheelchair and placed on a lounge chair were wheelchair leg rests and a leg splint.
      v. In the CD lounge there were clothes hangers, bed pillows and a cane placed on a lounge recliner.
      vi. In the lounge near room 19 there was one lounge recliner, a basin placed on top of a cabinet and found on the floor were personal clothing, three mechanical lift slings, a blue floor pad and a lambs wool covering.
      vii. In the AB dining room six customized wheel chairs and three wheel chairs were found.
      viii. Observations and interview with the Director of Housekeeping on 11/04/04 identified that information could not be provided regarding storage of additional wheel chairs and other items in lounges and dining area.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

10. Based on clinical record review and interview for 1 of 12 sampled residents (Resident # 36) who exhibited wandering behavior, the facility failed to develop a care plan that addressed the behavior. The findings include:
    a. Resident #36's diagnoses included Alzheimer's disease, atrial fibrillation and hypertension. An assessment dated 9/21/04 identified the resident with short term and long-term memory loss and moderately impaired decision making abilities. The assessment also identified that the Resident wandered 4 to 6 days in one week. Interview and review of Resident #36's care plan with the unit manager on 11/2/04 at 10:50 AM indicated that although the care plan identified non-specific interventions that included residents' wandering, it failed to identify specific interventions as to how the resident was to be monitored.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2,4I).

11. Based on record review and staff interview for 3 of 11 sampled residents (Resident #s 3, 5, 12, 17,23,38,41 and 42), the facility failed to obtain a physicians order for medication given, complete an assessment for hydration, follow the physician's order, ensure acceptable standards of practice were maintained with the use of an indwelling catheter and/or remain with the resident during medication administration. The findings include:
    a. Resident #3's diagnoses included Alzheimer's disease, Hypertension (HTN), Peripheral Vascular disease (PVD) and Failure To Thrive. Review of a nutritional progress note dated 10/25/04 recommended Argineid, Multivitamin, Zinc and Vitamin C. A physicians order dated 10/28/04 did not included Arginaid. Review of the medical administration record identified that Arginaid was given on 10/28/04, 10/29/04 and 10/30/04. In an interview on 11/01/04 at 10:00 AM the charge nurse stated that she thought she had obtained the order. According to Appleton and Lange, Clinical Nursing Skills, Fourth Edition, 1996, medication must have a Physician's order or prescription before it can be legally administered to a patient.
    b. Resident #5's diagnoses included Alzheimer's disease. An assessment dated 6/08/04 identified short and long-term memory deficits and moderately impaired decision-making abilities. A hospital discharge summary dated 7/14/04 identified Resident #5 was admitted to the hospital on 7/07/04 with a diagnosis of dehydration and acute renal failure. A care plan dated 7/14/04 identified poor oral intake with interventions that included to offer oral fluids frequently and monitor intake and output and for signs of dehydration. A dietician assessment dated 7/14/04 identified poor oral intake with interventions that included offering oral fluids frequently. The July 2004 intake and output record from 7/14/04 through 7/20/04 identified a daily fluid intake of 660 milliliters (ml) to 1020 ml. A nurse's note dated 7/20/04 at 7 :00 PM indicated the resident ate a spoonful of supper, refused to open her mouth and refused the supplement. A nurse's note dated 7/21/04 at 1:30 PM noted Resident #5 was weak, lethargic and consumed a small amount of fluids. The physician was notified and directed to obtain laboratory values. A laboratory report dated 7/22/04 indicated a blood urea nitrogen (BUN) level of 50 mg/dl (normal value 7-17 mg/dl), sodium level of 156 mg/dl (normal value 135-145 mg/dl) and a creatinine level of 1.9 mg dl (normal value 0.7 - 1.2 mg/dl). The nurse's note dated 7/23/04 identified that Resident #5 was transferred to the hospital

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for an evaluation. The hospital discharge summary dated 7/23/04 identified an admission diagnosis of dehydration, hyponatremia and acute renal failure. Interview wit h the dietician on 11/2/04 at 11:15 AM identified the resident's estimated fluid needs to be between 1100 m. and 1300 m. a day. Review of the clinical record with the unit manager on 11/02/04 at 10:40 AM failed to identify that although fluid intake was recorded below estimated daily needs from 7/14/04 through 7/21/04, an evaluation for possible dehydration was completed or that fluids were offered frequently. Additionally, the intake and output record failed to identify the number of episodes of incontinence or the amount of the incontinence. According to the Standard Nursing Practice, Third Edition, 2001, to assess for risk of dehydration, vital signs and skin turgor must be monitored every four hours. An increased pulse rate, decreased blood pressure and poor skin turgor or dry mucous membranes are signs of dehydration. Intake and output needs to be monitored to determine body fluid status.

c. Resident #12's diagnoses included Parkinson's disease and dementia. A quarterly assessment dated 7/9/04 identified the resident was severely cognitively impaired and required extensive to total assistance with activities of daily living. Nurse's notes dated 7/27/04 at 10 PM identified the resident complained of pain of the upper left extremity and a physician's order for an x-ray was obtained. Further review of the nurse's notes from that time until 7/29/04 identified that the resident continued to complain of pain. On 7/29/04 at 10 PM the x-ray was done, 2 days after physician order was obtained. On 7/30/04, at 12:40 PM the results of the x-ray identified dislocation of the left shoulder. The resident was transferred to the emergency room and underwent a closed reduction of the shoulder. Interview on 11/03/04 at 10:30 AM with the DNS identified that the x-ray should have been done when it was ordered. According to Mosby's Fundamentals of Nursing, Fifth Edition, 2001, the physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients.

d. Resident #17's diagnoses included chronic dementia and depression. A quarterly assessment dated 8/20/04 identified the resident had a short-term memory problem and required extensive assistance and/or total assistance of staff for activities of daily living. Physician orders dated 10/20/04 directed the administration of Vitamin C, 500 mg., two times a day. Observation on 11/01/04 at 9:30 AM. identified two orange colored tablets, in a medication cup, on the resident's bedside table. Observation at 10:20 AM with LPN#1 identified the tables were vitamin C 500 m.g. Interview and review of the clinical record at 11:00 AM with LPN#1

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identified the resident not been assessed for the ability to safely self-administer medications. It further identified the medications should not be left at the bedside.

e. Resident #23's diagnoses included diabetes mellitus, peripheral vascular disease and bladder atony. An assessment dated 6/9/04 identified short and long-term memory deficits and the utilization of an indwelling bladder catheter. The care plan dated 6/23/04 identified a diagnosis of a neurogenic bladder with interventions that included utilizing a leg bag during waking hours. Facility documentation dated 8/9/04 at 4:15 PM identified the charge nurse was called to the resident's room by nurse aide#1 because the indwelling catheter was wrapped around a bar that rotated with movement underneath the wheelchair. The catheter was pulled tight and the tension was causing pressure to the penis. The resident was yelling out in pain. The Assistant Director of Nurses (ADNS) assessed the situation and stated the catheter needed to be cut. Nurse aide#1 started to cut the catheter with a knife and the ADNS told her to wait and left to get a pair of scissors. With the charge nurse in the room attempting to untangle the catheter, nurse aide#1 cut the catheter with the knife. A nurses note dated 8/9/04 at 7:00 PM identified Resident #23's indwelling catheter was wrapped tightly around the bottom of the wheelchair causing trauma to the penis. A nurse aide picked up a kitchen knife and cut the catheter causing a section of the catheter tubing to retract into the bladder. The physician was notified and directed to transfer the resident to the emergency department for treatment. A hospital interagency referral form dated 8/9/04 identified that a cystoscopy was performed to remove the proximal end of the indwelling catheter from the bladder. In a statement provided to the facility on 8/9/04, nurse aide #2 stated the charge nurse was holding the catheter when nurse aide#1 cut the catheter with the knife. Nurse aide#1 in an interview on 8/13/04 at 3:15 PM stated she heard the ADNS state the catheter needed to be cut. The resident was screaming and when she saw the knife on the table she cut the catheter with the knife. Nurse aide#1 further stated that the charge nurse held one end of the catheter when she cut it to release it from the wheelchair bar. The charge nurse in an interview on 8/13/04 at 11:30 AM stated the ADNS repeated several times that the catheter needed to be cut to release the pressure. Although the charge nurse stated he was kneeling next to the nurse aide attempting to release the catheter tubing from the bar of the wheelchair, he was unaware the nurse aide cut the catheter. According to Fundamentals of Nursing The Art and Science of Nursing Care, Fourth Edition, copyright 2001. To remove a foley catheter make sure the balloon is deflated before attempting to remove the catheter. This is done by inserting a syringe into the balloon valve and aspirating the fluid used to inflate the balloon. Always verify the size of the balloon, which is

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printed either on the catheter or documented in the chart, so you know how much fluid to remove before proceeding. Do *not* cut the tubing with scissors.

f. Resident #38's diagnoses included chronic obstructive pulmonary disease. A Minimum Data Set (MDS) dated 8/04/04 identified short and long-term memory deficits. Observation on 10/31/04 at 8:45 AM identified Albuterol and Nasonex inhalers on the bedside table. The charge nurse was administering medication around the corner and down the hall from Resident #38's room. Review of the clinical record with the Assistant Director of Nurses on 10/31/04 at 8:45 AM. failed to identify that the resident was assessed for self-administration of medication. According to Pharmacology, A Nursing Practice, Second Edition, 1997, guidelines for administration of medications state to stay with the client until medications are taken.

g. Resident #41's diagnoses include pneumonia due to staphylococcus, chronic obstructive pulmonary disease (COPD) and dementia. Physician order dated 8/26/03 identified Duoneb one unit dose via nebulizer four times a day at 9 AM, 1 PM, 5 PM, and 9 PM. Quarterly Minimum Data Set (MDS) dated 5/25/04, identified resident with memory problems and moderately impaired cognitive skills for decision making. Observations on 9/8/04 at 1:35 PM identified Resident #41 in a chair with a facemask over their mouth and nose and mist escaping with no staff present. Interview with the charge nurse on 9/8/04 at 1:40 PM identified the she routinely stays with Resident #41 during his nebulizer treatment but was not with the resident this time.

h. Resident #42 diagnoses include COPD and severe emphysema. Annual assessment dated 7/21/04 identified resident independent with cognitive skills for decision-making. Physician order dated 7/28/04 identified Duoneb one unit dose via nebulizer four times daily at 9 AM, 1 PM, 5 PM, and 9 PM Resident Care Plan (RCP) dated 7/14/04 identified COPD as a concern with the approach of patient family teaching use of Metered Dose Inhaler (MDI), pulmo aide and oxygen. Review of clinical record failed to identify patient or family education on these topics. Observation on 9/8/04 at approximately 1:20 PM identified Resident # 42 sitting on the side of the bed with a misting nebulizer in his hand with no staff present. Interview with Resident #42 on 9/8/04 at 1:21 PM identified that resident completes his own breathing treatments including turning off the nebulizer machine. According to *Fundamentals of Nursing: The art and science of nursing care, 2001* "The nurse should remain with the patient and see that the medication is taken"

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

12. Based on clinical record review and interview for three sampled residents (Resident #s 7, 10 and 17), the facility failed to follow the plan of care. The findings include:
    a. Resident #7's diagnoses included hyponatremia. A quarterly assessment dated 8/17/04 identified the resident was alert and oriented. The resident care plan dated 8/31/04 identified a fluid volume deficit secondary to hyponatremia and a 500 cc fluid restriction. Interventions included to monitor intake and output each shift. Review of intake and output sheets dated 9/17/04 through 10/31/04 identified 41 out of 135 shifts lacked documentation of the resident's intake. Interview on 11/1/04 at 12:05 PM with the unit manager identified when a resident is on intake and output the charge nurse is responsible at the end of each shift to total up what the resident's intake and output was for that shift.
    b. Resident #10's diagnoses include depression, dementia and hypotension. The care plan dated 10/14/04 identified that the resident was to have behaviors monitored, note behaviors on the medication administration record and that this resident had behaviors of yelling at others. The resident's physician's orders indicated that the resident was on Zyprexia 7.5 mg every night and Zyprexia 2.5 mg every morning. The behavior monitoring sheets dated 4/04 - 10/04 identified that behaviors were not monitored consistently. Interview with the unit manager on 11/3/04 identified that she was instructed that she did not have to record behaviors anymore.
    c. Resident # 17 had diagnoses of Anemia and Chronic Dementia. A significant change assessment dated 5/10/04 and a quarterly assessment dated 8/20/04 identified the resident was moderately cognitively impaired and required extensive to total assistance of staff for activities of daily living. Nurse's notes dated 6/09/04 noted laboratory results identified critically low hemoglobin and hematocrit. Further review of the nurse's notes dated 6/10/04 identified that the resident was sent out for blood transfusions. Physician's orders dated 7/21/04 directed to obtain a complete blood count on the first Monday of every month for anemia. Interview and review of the clinical record on 11/1/14 at 11:00 AM with the licensed nurse identified that the last complete blood document was done on 8/2/04. It further identified that at that time the hemoglobin was 9.9 (normal 12.5 - 16.0) and the hematocrit was 30 (normal 37-47). Further interview identified that the order for blood work was not documented in the laboratory book and subsequently not done in 9/2004 and 10/2004. It further identified it had not been scheduled for 11/1/04 as ordered.

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A).

13. Based on clinical record review, observation and staff interview for 1 of 11 sampled residents (Resident #22) who was totally incontinent, the facility failed to ensure that care was provided in a timely manner. The findings include:
    a. Resident #22's diagnoses included dementia. The Minimum Data Set (MDS) dated 10/6/04 identified short and long term memory problem, severely impaired cognition, the need for total assistance with all Activities of Daily Living (ADL's), total incontinence with bowel and bladder and a stage I pressure ulcer. The care plan dated 10/18/04 directed to assist with turning and repositioning every two hours, check for incontinence every two hours and provide perineal care after each incontinence and reduce pressure off heels. Observations on 11/01/04 identified that between 2:45 PM and 5:45 PM (3 hours) the resident was not checked for incontinence and/or repositioned while in the custom wheelchair. Interview with the nurse aide on 11/01/04 at 6:25 PM identified that she normally will provide care every two hours but the facility was short staffed and she was busy.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(C).

14. Based on clinical record reviews, observations and interviews for 5 of 12 residents (Resident #s 1, 2, 4, 9 and 26) who had pressure sores and/or history of pressure sores, the facility failed to provide the necessary treatment and services. The findings include:
    a. Resident #1's diagnoses include peripheral vascular disease, renal failure and diabetes. The current physicians orders identified that the resident was receiving the treatment of normal saline and dry protective dressing to all areas on his coccyx, legs and heels. Observation of the resident on 10/31/04 at 10:35 AM identified that the resident had numerous areas to the coccyx, legs, heels and leg areas that were necrotic with purulent drainage and odor was noted from these areas. An open area to the left calf area had copious amounts of purulent drainage with odor noted and the bandage had not been changed since 10/29/04. The physician's orders and current treatment record failed to identify that a treatment was ordered for the left calf area. Review of the weekly skin-tracking sheet failed to identify that the resident had an open area to the left calf area. Interview with the charge nurse on 10/31/04 at 10:50 AM identified that she was putting a dry protective

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dressing on the left calf area and dressing had not been changed since 10/29/04. Further interview identified that she was not aware that there was a physician's order for area to the left calf area. Interview with the hospice nurse on 11/03/04 at 9 AM identified that she was not aware that wounds had so much drainage and if she had, she would have recommended changing the treatment for those wounds.

b. Resident #2's quarterly assessment dated 8/17/04 identified the resident with severe cognitive impairment, requiring total assistance of staff for activities of daily living (ADL) and as having a stage III (3) pressure ulcer. The resident care plan dated 8/31/04 identified the resident having a stage III pressure ulcer on the right hip. Interventions included treatment as ordered. Physician's orders dated 8/04 identified to wash the right hip wound with normal saline, apply aqua pack and cover with a dry protective dressing daily. Observation on 11/1/04 at 10:05 AM. identified the charge nurse removed the soiled dressing which identified a large amount of green purulent draining on the dressing and in the wound bed. The charge nurse was observed then to spray the wound bed and cleanse the edges of the outside of the wound then pack the wound with aqua dressing and covered it without the benefit of cleansing the entire wound. Interview on 11/01/04 at 10:30 AM with the involved charge nurse identified he would do the treatment again. Interview with the unit manager on 11/2/04 at 11:30 AM identified the treatment should be done according to physician's orders. Observation on 11/2/04 at 1:45 PM. identified 2 nurses' aides assisting Resident #2 out of bed and into a recliner chair. The chair was noted to be without the benefit of a pressure relieving device for 1-½ hours. Interview with the unit manager on 11/2/04 at 11:30 AM identified a pressure relieving device should have been on the resident's chair prior to getting out of bed.

c. Resident #4's diagnoses included dementia, diabetes and history of a pressure ulcer on the right buttock. The Minimum Data Set (MDS) dated 10/14/04 identified short-term memory problem, severely impaired cognition, the need for total assistance with all activities of daily living, total incontinence with bowel and a stage III pressure ulcer. The care plan dated 10/27/04 identified to provide hygiene after voiding followed by moisture barrier. Observation on 10/31/04 at 11:30 AM identified that the resident was provided perineal care but was without the benefit of being provided a moisture barrier. Interview with the nurse aide on 11/03/04 at 10:30 AM failed to identify why moisture barrier was not applied on 10/31/04. Interview with the infection control nurse on 11/3/04 at 10:30 AM. identified that barriers should be applied after incontinent care.

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d. Resident #9 was readmitted to the facility with diagnoses that included Alzheimer's disease and hypertension. A nursing admission assessment identified bilateral three plus pitting edema to the lower extremities and the feet. It further identified that the skin was intact on the feet. A Braden scale completed on 5/7/04 indicated a low risk for pressure ulcer development. A Minimum Data Set (MDS) dated 5/14/04 identified short and long-term memory deficits, severely impaired decision-making abilities, extensive assistance required for bed mobility and the absence of impaired skin integrity. A nurse note dated 5/19/04 at 12:15 PM identified a dark black discoloration of the left heel and a 4.0 cm by 6.0 cm open blister on the right heel. The right heel was further described with thin black colored skin, macerated wound edges and bleeding. The physician was notified and wound treatments obtained. Review of the clinical record with the unit manager on 11/01/04 at 12:15 PM failed to identify that interventions were instituted upon admission 5/07/04 to address the potential for impaired skin integrity. Additionally, the clinical record lacked documentation that consistent monitoring of the edema and skin integrity was completed.

e. Resident #26 diagnoses include diabetes mellitus, osteomyelitis and status post right above the knee amputation. The Minimum Data Set (MDS) dated 7/27/04 identified that the resident was without short or long-term memory deficits and was cognitively independent. A care plan dated 8/10/04 identified a problem with skin breakdown on the buttock due to decreased mobility, diabetes and anemia. Frequent repositioning and treatment as ordered were identified as interventions for a superficial open area on the right and left buttock on the 9/19/04 care plan. Nurse's notes on 10/12/04 identified an area on right and left buttock and a physician's order for the use of duoderm. The care plan dated 10/18/04 reflected that the resident refused to go back to bed for incontinent care. Facility documentation dated 10/22/04 reflects that the resident had gone to the supervisor's office to request that she be put back to bed stating she had been up for 8 ½ hours without being toileted. Observation on 10/31/04 revealed the resident being transferred via hoyer back to bed at 4 p.m. The hoyer pad and the wheelchair cushion were saturated with urine. Subsequent interview with the resident revealed that she had been up from 9:30 AM and in the wheelchair for 6 ½ hours without the benefit of being provided with assistance with toileting.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and or (m) Nursing Staff (2)(C)

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15. Based on clinical record review, observation and staff interview for one sampled resident (Resident #23), who had a contracture, the facility failed to ensure that the splint was applied as per the physician order. The findings include:
    a. Resident #23's diagnosis included depression and dementia. The MDS dated 9/8/04 identified short and long term memory problem, moderately impaired cognition, the need for total dependence with dressing and limitation of range of motion to the hand and arm. Physician orders dated October 2004 directed to utilize a right hand splint daily between 9:00 AM and 4:00 PM. Intermittent observations on 10/31/04, 11/1/04 and 11/2/04 between 9:00 AM and 4:00 PM identified that the resident was without the benefit of the right hand splint. Interview with the Assistant Director of Nurses (ADNS) on 11/2/04 at 10:15 AM identified that she was unaware of why the splint had not been applied and that the splint was found behind the dresser. Interview with the nurse on 11/2/04 at 10:15 AM identified that she did know that a while back the resident did wear a splint but she didn't know that she was still using it and that she had not seen it not [illegible] yesterday and today.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A).

16. Based on observation and staff interview, the facility failed to provide a hazard free environment. The findings include:
    a. An observation on 11/03/04 at 9:30 AM with the Director of Housekeeping, identified that in B Wing lounge a resident was located in the lounge sitting in a wheelchair. Also in the B Wing lounge was an electric wheel chair plugged in to an electric outlet. Interview with the Director of Housekeeping, identified that the electric wheel chair was being charged.
    b. Observation of the F Wing soiled utility room on 11/03/04 at 10:10 AM with the Director of Housekeeping, identified that the laundry chute was left open. Interview with the Director of Housekeeping noted that he was aware the chute was to be closed when not in use and was found open because there was no self-closure device on the chute.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A).

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17. Based on clinical record review, observation and interview for 7 of 20 sampled residents (Residents #5, 8, 10, 18, 21, 33, and 39), the facility failed to provide the necessary supervision and/or assistive devices to prevent an accident. The findings include:
    a. Resident #5's diagnoses included Alzheimer's disease. A fall risk assessment dated 5/21/04 identified a high risk for falls. An assessment dated 6/08/04 identified short and long-term memory deficits, moderately impaired decision-making abilities and a history of falls within the last thirty days. The care plan dated 5/21/04 indicated a high risk for falls with interventions that included to remind resident to call for assistance as needed. A nurse's note dated 7/5/04 identified that on 7/04/04 at 11:15 PM Resident # 5 was found sitting on the floor next to the bed. A nurse's note dated 7/06/04 at 7:45 AM identified Resident #5 was found sitting on the floor outside the bathroom. Upon assessment a left knee abrasion was noted. Review of the clinical record with the unit manager on 11/02/04 at 11:00 AM failed to identify that a re-evaluation was completed after the fall on 11/04/04 until 7/06/04 after the 7:45 AM fall.
    b. Resident #8's quarterly assessment dated 8/17/04 identified the resident with moderately impaired cognition and impaired vision. The resident care plan dated 8/27/04 identified the resident as a smoker and had been assessed as an unsupervised smoker with precautionary measures. Interventions include reminder of smoking policy, resident to wear a smoking apron and not to have lighting materials on self or in the room. Nurse's notes dated 9/23/04, 9/26/04 and 10/24/04 identified that R#8 discarded her cigarette and hit another resident with the cigarette butt, was found outside with cigarettes and no smoking apron on and/or was found in the lobby with cigarettes. Social service notes dated 9/23/04 identified a decision was made to have identify R#8 as a supervised smoker. Nurse's notes dated 9/29/04 identified the resident purchased cigarettes from another resident and at times was smoking unsupervised. During an interview on 11/03/04 at 10:10 AM the charge nurse stated no new interventions were implemented after the incidents in September and October. She further stated that now all residents are supervised and the cigarettes are locked up.
    c. Resident #10 diagnoses include depression, dementia, and hypotension. Nurse's notes dated 5/22/04 identified that the resident had wandered outside of building in parking lot and was brought back into building by nurses aides. On 5/26/04 at 4:50 PM the resident had wandered outside of building and fell downstairs in wheelchair and had lacerate his nose and had multiple bruises and skin tears. The current physician's order identified that this resident was to be checked every 15 minutes. Review of the documentation from 5/27 - 11/02/04 identified that this resident was

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not monitored consistently. Further review identified that resident was not monitored on the evening shift. Observation of the resident from 10/31 - 11/01/04 identified the resident wandering in hallway in the wheelchair. The Resident was observed on a different floor numerous times without supervision. Observation of the resident at 11:55 AM on 11/02/04 identified the resident on a different floor wandering. An interview with the charge nurse on 11/02/04 at 12:45 PM revealed that she last saw the resident at the nurse's station at 12:00 PM. Review of the documentation of every 15 minutes checks noted that the resident was not checked since 11:00 AM. Subsequent to surveyor inquiry, the charge nurse filled out check sheets from 11:00 AM to 12:45 PM.

d. Resident #18 diagnoses include Schizophrenic disorder, vascular dementia and degenerative joint disease. The Minimum Data Set (MDS) dated 9/03/04 identified short-term memory deficit, intact long-term memory and moderately impaired cognition. Review of the nurse's notes on 8/28/04 revealed that every fifteen-minute check had been instituted. The clinical record demonstrated that on 10/04/04 the resident eloped and was subsequently admitted to the hospital until 10/19/04 when she returned to the facility. Review of the care plan dated 10/20/04 revealed that the resident was at risk for elopement, refuses to wear Wanderguard and will continue on every fifteen-minute checks. Nurse's note dated 10/28/04 stated the resident was threatening to leave the facility followed by her denial that she wanted to leave. Resident flow sheets dated 11/01/04 reflect the resident had been checked at 15 minutes intervals until 5:45 AM. Review of the nurse notes 11/01/04 reflected that a Certified Nurses Assistant (CNA) called at 6:20 AM and stated she had seen the resident on the bus. Telephone call by the daughter at 7:20 AM revealed the resident was located in a donut shop in a different town. Interview with the Certified Nurses Assistant on 11/03/04 at 10:30 AM revealed that the last time she saw the resident was around 2:00 AM and she wasn't aware she was on every 15-minute checks. Interview on 11/03/04 at 2:00 PM with the nurse on duty that night revealed that she filled out the form for the checks but it was a group effort, she didn't actually see the resident but staff would report to her.

e. Resident #21's diagnoses include chronic obstructive pulmonary disease, depression and gout. The social service evaluation on 10/29/04 identified that the resident presently smoked and has had a smoking history of 60 years. Review of the care plan dated 10/29/04 identified that the resident did not have a care plan for smoking. Further review identified that a smoking assessment was not done for this resident. Observation of the resident on 11/01/04 at 11:30 AM identified the resident outside of building smoking independently. Interview with the unit

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manager on 11/02/04 at 12:50 AM identified that she was not aware that the resident smoked. Interview with the social worker on 11/01/04 identified that the resident's assessment was not done. Subsequent to surveyor inquiry, the social worker completed a smoking assessment and identified this resident as independent with smoking practices.

f. Resident #33 diagnoses included Bipolar disorder and depression. An assessment dated 8/31/04 identified decision-making difficulty in new situations. A smoking assessment dated 2/25/04 identified Resident #34 was able to smoke independently with precautionary measures. The precaution measures included to keep lighting materials at the nurse's station and to wear eyeglasses due to impaired vision. A nurse's note dated 10/26/04 identified Resident #34 was outside smoking independently while the right pocket of her coat was noted to be on fire. Another resident extinguished the fire by using a cup of water. Facility documentation dated 10/26/04 identified Resident #33 was putting out her cigarette in the ashtray and the ash dropped into the pocket of her coat. The pocked was noted to be smoldering but no flames were visible. The smoking assessment dated 10/26/04 identified supervised smoking, the use of a smoking apron and all smoking materials kept at the nurses' stations. Observation on 11/01/04 at 2:30 PM identified Resident #33 on the smoking patio, took cigarette and lighter out of her pocket and lit the cigarette. After approximately thirty seconds, an with the prompting from another resident, Resident #33 retrieved the smoking apron from the basket of the walker and put it on over her head. During the process the resident continued to hold onto the lit cigarette. Interview with the unit manager on 11/01/04 in the morning that indicated Resident #33 was assessed to be an independent smoker with the use of a smoking apron. Review of the clinical record with the unit manager on 11/02/04 at 9:30 AM failed to identify that observations of the resident smoking were completed form 10/26/04 through 11/01/04 when the supervised smoking and ability to hold smoking materials was revoked.

g. Resident #39's diagnoses included depression with agitation at times. The Minimum Data Set (MDS) dated 9/29/04 identified short-term memory problems, moderately impaired cognition and independence in locomotion when in wheel chair. Observation on 11/01/04 at 4:00 PM identified that the resident self-propelled to the nursing station with a razor (shaver) in his hand. The resident was observed to dry shave his chin. Interview with the Licensed Practical Nurse (LPN), on 11/01/04 at 4:00 PM identified that the resident frequently rummages through other resident rooms and or the nourishment room and needs redirection. Interview

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

with the nurse aide on 11/01/04 at 4:05 PM identified that this resident is frequently seen with razors and is hard to redirect.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(C).

18. Based on clinical record reviews, interviews and observations for one sampled resident (Resident #6), the facility failed to ensure that resident received proper treatment and care for special services. The findings include:
    a. Resident #6's diagnoses include hypertension, chronic obstructive pulmonary disease and renal failure. The resident's assessment dated 10/25/04 identified that the resident utilized oxygen therapy. The physician's orders dated 10/21/04 identified that the resident utilized oxygen at one liter while awake and two liters during hours of sleep. Review of the resident's current care plan failed to identify that the resident utilized oxygen. Further review of the nurse aide assignment sheet failed to identify that the resident utilized oxygen. Observations of the resident on 10/31/04 at 9:00 AM identified the resident did not have oxygen on. Interview wit the charge nurse on 10/31/04 identified that the resident needed to have her oxygen on.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A).

19. Based on clinical record review and interview for one sampled resident (Resident #20), the facility failed to provide a therapeutic diet that was safe in relation to a food allergy. The findings include:
    a. Resident #20's diagnoses included chronic obstructive pulmonary disease, insulin dependent diabetes and asthma. The Minimum Data Set (MDS) identified intact short and long-term memory and cognition. The Resident profile dated 1/20/04 specified a mushroom allergy. The care plan updated 6/09/04 addressed the Resident's allergy to mushrooms. Facility documentation dated 8/07/04 identified the resident was rushed back to E Wing after eating mushrooms with her face flushed and with difficulty breathing. 911 was called and she was taken to the hospital. The Emergency Room record 8/07/04 indicated the resident was treated with epinephrine and returned to the facility with orders to renew the Epi-pen. Interview with the Resident on 11/03/04 at 10:30 AM revealed that she had requested the cheeseburger pie without knowledge it contained mushrooms.

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Interview with the food service provider on 11/03/04 at 1:30 PM revealed that the request was received in the kitchen and sent to the resident by a dietary aide who was unaware of the mushrooms.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(C) and/or (q) Dietary Services (2)(C).

20. Based on clinical record review, observation and staff interview for 2 of 7 sampled residents (Resident #s 4 and 27), who were incontinent and/or had a wound, the facility failed to ensure that infection control practice was maintained. The findings include:
    a. Resident #4's diagnosis included dementia, a history of a decubitus ulcer with Methicillin Resistant Staphylococcus Aureus (MRSA) and a current ulcer on the right heel. The Minimum Data Set (MDS) dated 10/14/04 identified short term memory problem, severely impaired cognition, the need for extensive assistance with all activities of daily living (ADL's), total incontinence of bowel, the use of an indwelling catheter and a stage III (3) pressure ulcer. The care plan dated 10/27/04 directed to provide the resident with total assistance for bathing.
        i. Observation of morning care on 10/31/04 at 10:45 AM identified that after providing catheter care to Resident #4, the Nurse Aide (NA) failed to wash her hands and change gloves. The same washcloths were used to provide care to the resident's back. Linen used to care for the resident was noted multiple times to be placed on the bedside table.
        ii. Observation on 10/31/04 at 11:15 AM identified that after providing care to Resident #4, the NA put the soiled washcloths into and on the sink in the bathroom. Additionally, the NA caring for Resident #4 and the NA caring for Resident #4's roommate were noted multiple times to empty their soiled water basins, wash their hands and refill their water basins in the sink that contained the soiled wash cloths.
        iii. Observations on 10/31/04 at 11:30 AM identified that after providing care to Resident #4, the NA was noted to empty the water basin and leave the soiled washcloths in and on the sink in the bathroom. Additionally, although the NA did bag some of the soiled washcloths and remove them from the bathroom sink, some washcloths were noted to be left on the sink in the bathroom.
        iv. Observation on 11/02/04 at 12:05 PM identified that after completing a dressing change to the right heel ulcer the LPN removed the towel under the resident's right heel and placed it onto the bedside table.

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v. Observation on 11/02/04 at 12:15 PM identified that a wet wash cloth was noted to be on the sink. Interview with the ADNS on 10/31/04 at 1:05 PM identified that after bathing a resident; the soiled water is to be emptied into the toilet. Additionally, linen is not to be put on the bedside table or on the sink and is to be placed in the appropriate receptacle after completion of care.

b. Resident # 27's assessment dated 10/11/04 identified the resident was moderately cognitively impaired, required limited assistance with Activities of Daily Living (ADL) and had four stage II pressure ulcers. Physician's orders dated 10/17/04 directed that Xenaderm ointment be applied to the resident's buttocks four times a day. Observation on 11/2/04 and 11/3/04 noted the tube of Xenaderm was stored in the emesis basin with the resident's toothbrush in the resident's bathroom. Interview with the nurse on 11/3/04 at 10:30 AM noted that the Xenaderm should be stored on the treatment cart with the other topical medication.

c. Observation on 11/2/04 and 11/3/04 identified items in linen closets as follows: A-wing a plastic bag containing contracture books and a cardboard box filled with tissue boxes on the floor; B-wing two bedside floor mats and a cardboard box filled with tissue boxes on the floor; D-wing a package of disposable diapers and a package of isolation gowns on the floor; E-wing one empty cardboard box and the respiratory supply cart. F-wing a customized wheelchair a cardboard box full of tissue boxes, a siderail, a chair and a box of personal belongings. Interview with the Director of housekeeping on 11/3/04 at 10:15 AM noted that although housekeeping cleans the linen closets twice a week other things bedside linens are found in the closets.

d. Observation of the soiled utility rooms on 11/2/04 at 8:30 AM identified the following: The A-wing utility room identified a housekeeping cart, two large bags of trash on the floor next to the rubbish container, three clean intravenous poles and one folding walker in the room. The B-wing utility room contained a housekeeping cart and a large bag of trash on the floor next to the rubbish container. In C-wing utility room a housekeeping cart and three clean intravenous poles were noted. The Assistant Director of Nurses (ADNS) stated in an interview on 11/2/04 at 8:30 AM that trash was emptied every morning and she was unable to identify why the trash bags were on the floor. The Director of Housekeeping in an interview on 11/2/04 at 8:40 AM stated that during the day the housekeepers left the carts in the soiled utility room when they left the unit.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (t) Infection Control (3).

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21. Based on observation and staff interview, the facility failed to store medical records in a secured location. The findings include:
    a. Observation of the A-wing lounge on 11/2/04 and 11/3/04 identified five boxes stacked containing pieces of active medical records. Interview with the Assistant Director of Nursing on 11/3/04 at 9:15 AM identified that the records were not secured. Interview with the Unit Secretary on 11/3/04 at 11:10 AM identified that she had been called away and had not been able to finish putting the records away.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (4).

22. Based on clinical record review and interview for two sampled residents (Resident #2, 9), the facility failed to ensure the resident was seen by a physician and/or a history and physical was completed in a time manner.
    a. Resident #2 was admitted on 1/30/04 with diagnoses of chronic decubiti, pneumonia and malnutrition. Review of the clinical record and interview with the unit coordinator on 11/2/04 at 11:30 AM identified the admission history and physical and admission orders were not completed until 2/4/04 (5 days later).
    b. Resident #9 was readmitted to the facility on 5/7/04 with diagnoses that included Alzheimer's disease and hypertension. A history of physical dated 5/18/04 was completed by the attending physician. Although the resident was readmitted to the facility on 5/7/04, the attending physician did not complete a history and physical and/or evaluation of the treatment plan until 5/18/04 (11 days after readmission).

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (1).

STATE OF CONNECTICUT

Exhibit A1

DEPARTMENT OF PUBLIC HEALTH

June 9, 2005

Drieu Connors, Administrator
Wethersfield Health Care Center
341 Jordan Lane
Wethersfield, CT 06103

Dear Administrator:

Unannounced visits were made Wethersfield Health Care Center on March 15, 17 and May 9, 10, 11 12, 16, 17,18 and June 3, 2005 by representatives of the Health Systems Regulation for the purpose of conducting a licensure and certification inspection and multiple complaint investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut, which were noted during the course of the visit.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by June 22, 2005 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction, which includes the following components:

a. Measures to prevent the recurrence of the identified violation, (e.g. policy/procedure, inservice program, repairs, etc.).

b. Date corrective measure will be effected.

c. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Karen Gworek RN GNC

Karen Gworek, R.N.
Supervising Nurse Consultant
Health Systems Regulation

KEG DMS/jf

c: Director of Nurses
Medical Director
President

CT00003846, CT00003728, CT00003750, CT00003948, CT00003967, CT00003989

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. Based on clinical record review, observation and staff interview for 1 of 1 sampled residents (Resident #33) who self administered medications, the facility failed to provide a safe storage space for the medications and/or develop a care plan. The findings include:
   a. Resident #33's diagnosis included asthma and chronic obstructive pulmonary disease. The signed May 2005 monthly physician orders identified that Resident #33 could self- administer the medications Miacalcin Nasal spray, the nebulizer and inhalers. The assessment of residents ability to self-administer drugs form dated 11/1/04 identified that the resident was capable of self-administering the medications as stated above. Observation on 5/9/05, at 9:40 AM, identified a unit dose of nebulizer solution, Miacalcin nasal spray and 8 Tums tablets unattended in the resident's room on the bedside table. Interview with a Corporate Nurse on 5/9/05, at 9:45 AM, identified that although the resident was assessed to self-administer nebulizer, inhalers and the nasal spray, there was no order or assessment to self administer the other medications, that the medications could be stored at the resident's bedside in a locked box and not left on the bedside table. Review of the clinical record failed to identify a care plan with approaches that addressed the self-administration of medication. Facility policy on self administration and/or self storage of medications identified that if the interdisciplinary team determined that self administration and/or storage would be appropriate and safe for a resident, a physician's order is required. In addition, the policy indicated that residents who have orders for self-storage of medications must store their medications in a secured container.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(I).

2. Based on clinical record review, facility documentation, observations and staff interviews for 3 of 5 sampled residents (Resident #s 11, 17 and 21) who utilized clip seatbelts while in the wheelchair, the facility failed to conduct restraint assessments to determine the appropriate utilization of a restraint and/or for one resident (Resident #11) failed to ensure the proper use of siderails. The findings include:
   a. Resident #11's diagnoses included dementia and cerebral vascular accident. An annual assessment dated 11 18 04 identified that Resident #11 had memory deficits.

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severe cognitive impairment, required total assistance from staff for transfers, was non- ambulatory and utilized a trunk restraint. The assessment identified further that the resident resisted care and had a change in usual sleep pattern. A physical restraint form dated 12/15/04 identified the need for one side rail while in bed. Monthly physician's order signed in December 2004 directed for siderail use, one up, one down and a bed alarm at all times. Review of facility documentation dated 12/22/04 identified that Resident #11 was found on the floor at the foot of the bed at 11:45 PM, two siderails were noted to be in the up position and a range of motion assessment identified no apparent injuries. In an interview on 5/12/05, at 9:30 AM, the Unit Manager identified that the clinical record directed for one siderail up and one down. In an interview on 5/13/05, at 8:15 AM, the 11-7 AM nurse aide on duty 12/22/04, stated that both siderails were up. In addition, observation with the charge nurse on 5/12/05, at 11:00 AM, identified that Resident #11 was seated in a wheelchair with a clip seatbelt fastened and the resident was unable to release the clip of the seatbelt upon request. Review of the clinical record identified that the last restraint assessment was conducted on 12/3/03 for the clip seatbelt. Interview and review of the clinical record with the Unit Manager on 5/12/05, at 9:30 AM, lacked documentation that a restraint utilization and/or restraint reduction assessment had been conducted from 12/3/03 through 5/12/05 to determine the need for the continued utilization of the seatbelt.

b. Resident #17 had diagnoses that included dementia. A significant change assessment dated 2/19/05 identified that the resident had modified cognitive independence and required total assistance from staff for activities of daily living. Physician's order for May 2005 directed for Resident #17 to be out of bed to a wheelchair as tolerated. Observations from 5/9/05 through 5/13/05 identified Resident #17 utilized a clip belt restraint while seated in a wheelchair. On 5/9/05, at 3:00 PM, Resident #17 was seated in the wheelchair and upon request was unable to unfasten the seatbelt. Clinical record with the Unit Manager on 5/10/05, at 3:20 PM, failed to provide evidence that a restraint assessment had been conducted. In an interview on 5/11/05, the Minimum Data Set Coordinator stated she did not know why Resident #17 required a restraint while in the wheelchair.

c. Resident #21's diagnoses included dementia, hypertension, and rhabdomyolysis. An admission assessment dated 2/15/05 identified that Resident #21 had memory deficits, moderate cognitive impairment, required total assistance with transfers in

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and out of the bed/chair and was non- ambulatory. A restraint assessment dated 2/6/05 identified that restraints were not utilized. A fall risk assessment dated 2/15/05 identified that the resident was a high risk for falls. The Resident Care Plan dated 3/7/05 identified a history of falls with interventions to utilize a chair alarm. Observations from 5/9/05 through 5/12/05 identified Resident #21 seated in a wheelchair with a fastened clip seatbelt. Review of the clinical record on 5/12/05, at 9:30 AM, the Unit Manager was unable to locate documentation that Resident #21 had been assessed for a clip seatbelt. On 5/12/05, at 10:00 AM, observation with the charge nurse identified that the resident was unable to unfasten the clip belt upon request.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(A) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A) and/or Connecticut General Statutes Section 19a-550.

3. Based on clinical record review, facility documentation, and staff interviews for one sampled resident (Resident #34), the facility failed to provide personal care and/or administer medications, and/or identify the location of the resident to provide a safe environment for eight hours. The findings include:
   a. Resident #34's diagnoses included non-insulin dependent diabetes mellitus, cerebral vascular accident with aphasia and dysphagia with aspiration precautions. A quarterly assessment dated 4/5/05 identified that the resident had severe cognitive impairment, was totally dependent on staff for activities of daily living and incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 4/20/05 identified a potential for complications related to diabetes mellitus with interventions to administer diabetic medications as ordered. The RCP also identified a self-care deficit with interventions that included to toilet every two hours. Review of the April 2005 medication record identified the following medications were to be administered on the 3-11 PM shift: at 5:00 PM; Avandia 4 milligrams (mg), Lisinopril 2.5 mg, Norvasc 5 mg, Singulair 10 mg; at 6:00 PM, Duoneb 1 unit via nebulizer; at 9:00 PM; Super Nu-Thera 1 capsule, Metoprolol 50 mg, Pulmicort Respules 0.5 one unit via nebulizer after the Duoneb and Regular Insulin sliding scale coverage per the fingerstick bloodsugar results. The medication and treatment records directed to flush the gastrostomy tube with 350cc of water

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and cleanse the tube site with normal saline every shift. Facility documentation dated 5/3/05 identified that on 4/30/05, Resident #34 was placed in the D wing lounge at 6:00 PM by the family who upon leaving the unit reported to a nurse aide, Resident #34's location. At 11:30 PM (5 1/2 hours later) the family member returned to the unit, found the resident still seated in the lounge and brought Resident #34 to the D wing nurse's station. Further review of the documentation identified the charge nurse stated " I've been looking for her all night," the scheduled 5:00 PM, 6:00 PM and 9:00 PM medications had not been administered and the 9:00 PM fingerstick with parameters of insulin coverage was not conducted until 11:30 PM. In addition the resident was noted to be heavily soiled in urine and feces. Interview with the Nurse Aide on 5/13/05 at 1:10 PM stated when she went to get the resident to assist her to bed the resident was not in her room or in the dining room and reported it to the nurse, but she did not look anywhere else for the resident. She further stated she did not provide any personal care to Resident #34 throughout the shift (3:00 to 11:00 PM a total of eight hours). In an interview on 5/18/05, at 11:15 AM, an agency 3-11:00 PM charge nurse (LPN #5), on duty 4/30/05, stated that the only orientation she received from the facility was a review of some residents from the roster by the 7:00 AM to 3:00 PM charge nurse. LPN #5 further stated she had questioned a nurse aide as to Resident #34's location and the nurse aide had remarked that Resident #34 was not on her assignment. LPN #5 explained that nurse aides were asked to locate the resident, however, she (LPN #5) had gotten busy with treatments that she forgot about Resident #34 until the resident was brought to the nurse's station by the family member at 11:30 PM and at that time only the medications were administered per the family member's request. Review of facility documentation identified that Resident #34's daughter had indicated that LPN #5 had stated to her that "she did not know how to use the phone to call anyone". Review of the nursing schedules from 5/1/05 through 5/13/05 identified that agency nurses were scheduled for nine shifts. Review of the Agency Orientation records in correlation to the schedule identified that on 5/6/05 an agency nurse worked without the benefit of an orientation until 5/14/05. In addition, on 5 2 05, 5 3 05 and 5 5 05 agency nurses were noted on the schedule and although the facility identified that an orientation was conducted, the facility was unable to locate documentation to confirm this. Review of the facility documentation dated 5 6 05 identified that the facility had responded to Resident

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#34's family member's concerns, however, the facility failed to conduct a thorough investigation until surveyor inquiry on 5/12/05.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C) and/or Connecticut General Statutes 19a-550.

4. Based on clinical record review, facility documentation and interviews for 1 of 3 sampled residents (Resident #15) who reported rough handling during care, the facility failed to respond to the allegation and/or initiate an investigation in a timely manner. The findings include:
   a. Resident #15's diagnoses included right tongue and tonsillar squamous cell mass, depression, and tracheostomy. A significant change assessment dated 3/21/05 identified that Resident #15 had no cognitive impairment and was independent in activities of daily living. The Resident Care Plan (RCP) dated 4/4/05 identified that the resident had a behavioral symptom of resisting care. Interventions directed to keep the resident safe, do not attempt to provide care when combative and re-approach when calm. In an interview on 5/9/05, at 11:15 AM, Resident #15 stated that during tracheostomy care on 5/7/05, at 10:00 PM, he became upset with the respiratory therapist because the therapist forcefully pulled on his head. Resident #15 explained that he had reported the incident to the charge nurse immediately following the event. On 5/9/05, at 11:45 AM, in an interview the Unit Manager indicated that she was unaware of the 5/7/05 incident. In a follow-up interview on 5/10/05, at 9:20 AM, the Unit Manager identified that an investigation of the incident had not been initiated until 5/10/05. In an interview on 5/10/05, at 2:30 PM, the Assistant Director of Nurses identified that the appropriate reports had been completed and the appropriate authorities notified 5/10/05, three days after the incident was reported.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2) and or (g) Reportable Event (2) and/or (g) Reportable Event (6).

5. Based on clinical record review, facility documentation and interviews for 1 of 1 sampled residents (Resident #15) who required tracheostomy care every shift, the facility failed to honor the resident's refusal of care. The findings include:

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a. Resident #15's diagnoses included right tongue and tonsillar squamous cell mass, depression, and tracheostomy. A significant change assessment dated 3/21/05 identified that Resident #15 had no cognitive impairment and was independent in actualities of daily living. The Resident Care Plan (RCP) dated 4/4/05 identified that the resident had a behavioral symptom of resistance to care. Interventions directed to keep the resident safe, do not attempt to provide care when combative and re-approach when calm. In an interview on 5/9/05, at 11:15 AM, Resident #15 stated that during tracheostomy care on 5/7/05, at 10:00 PM, he became upset with the respiratory therapist because the therapist forcefully pulled his head. Resident #15 explained that he had requested the therapist leave his room more than once, however, the therapist remained in the room which continued to upset the resident and the therapist left when the charge nurse intervened. In an interview on 5/9/05, at 12:25 PM, the charge nurse identified that the respiratory therapist was present when she had entered Resident #15's room. The charge nurse explained that although the resident requested the therapist to leave, the therapist did not leave the room until she (the charge nurse) had instructed the therapist. In an interview on 5/11/05, at 3:15 PM, the respiratory therapist stated that Resident #15 become upset while waiting for the charge nurse to assess a wound around the tracheostomy site and although the resident requested for her to leave the room, she remained until the charge nurse asked her to leave.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D).

6. Based on clinical record review, facility documentation, and staff interview for 1 sampled resident (Resident #34) who had an incident of inappropriate care and services, the facility failed to implement social service interventions. The findings include:
   a. Resident # 34's quarterly assessment dated 4/5/05 identified that the resident had severe cognitive impairment and was totally dependent on staff for activities of daily living. The Resident Care Plan dated 4/20/05 identified the use of psychotropic medications secondary to depression, with interventions to include social service consult as needed. Facility documentation dated 5/3/05 identified a concern reported by Resident #34's family regarding the provision of care and services on 4/30/05. Review of Resident #34's clinical record and interview with

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the Social Worker on 5/16/05, at 12:50 PM, stated that the concern was reported to her by a staff member, she spoke with the nursing staff to see if there were any changes in the resident's psychosocial well being, she did not assess and/or visit the resident herself and did not document any of the findings and/or outcomes in the resident's clinical record.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (s) Social Work (7).

7. Based on clinical record review and interviews for 2 of 4 sampled residents (Resident #s 8 and 17) who had a history of dehydration and/or an alteration in skin integrity, the facility failed to develop a comprehensive care plan based on resident assessments. The findings include:
   a. Resident #8's diagnoses included dehydration and dementia. An annual assessment with a Resident Assessment Protocol Summary (RAPS) dated 4/5/05 identified that Resident #8 triggered for dehydration. Review of the clinical record identified that Resident #8 had been hospitalized on 11/6/04 for dehydration. The Resident Care Plan (RCP) dated 4/11/05 identified that Resident #8 failed to identify that a care plan was developed and interventions initiated specific for dehydration. In an interview on 5/11/05, at 11:45 AM, the MDS Coordinator was unable to explain why the dehydration was not addressed in the RCP.
   b. Resident #17's diagnoses included dementia. A significant change assessment dated 1/23/05 identified that the resident had modified cognitive independence and was totally dependent on staff for activities of daily living. Nurse's note dated 1/23/05 identified a laceration on the left lower leg. Nurse's note dated 3/31/05 identified an old ecchymotic opened area to the right shin. Review of the clinical record with the Unit Manager and the RCP Coordinator on 5/10/05 failed to provide evidence that a care plan was developed to address an alteration of skin integrity tears.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(I).

8. Based on clinical record review, facility documentation and interviews for one of two sampled residents (Resident #29) who had a history of elopement, the facility failed to

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assess and revise the care plan after the third incident of elopement to prevent further occurrences. The findings include:

a. Resident #29's diagnoses included arthritis, dementia and a history of alcohol abuse. The admission face sheet dated 9/23/04 identified that Resident #29 was conserved. The admission assessment dated 9/30/04 identified that Resident #29 had memory deficits, moderate cognitive impairment, resisted care and required minimal assistance with ambulating. The Resident Care Plan (RCP) dated 9/24/04 identified decreased functional mobility. Interventions directed for supervision with ambulating. Review of facility documentation, nurse's notes and the RCP from 10/26/04 through 11/21/04 identified the following: on 10/26/04, 3-11 PM, Resident #29 was found outside the facility asking for directions, a wanderguard was initiated on the right wrist. On 11/17/04, at 2:10 PM, a nurse aide called the facility to inform staff that Resident #29 was noted walking down a highway that is 0.6 of a mile from the facility, every fifteen-minute checks were initiated while the wanderguard was under repair. On 11/19/04, at 4:00 PM, Resident #29 was found seated in his room with a six-pack of beer, the resident admitted to leaving the facility to purchase the beverage, however no new interventions were initiated to the care plan. On 11/21/04, at 9:30 PM, Ativan 0.5 milligrams was administered for increased anxiety, Resident #29 had stated that he wanted to leave the building, at 10:00 PM Resident #29 was noted to be missing and at 10:30 PM the local authorities contacted the facility to inform them that Resident #29 was found on the same highway as on 11/17/04. Subsequent to the incident, Resident #29 was placed on one to one supervised observation until transfer to the hospital for an evaluation and admission. Review of the facility's investigational report dated 11/24/04 identified that Resident #29 was placed on close observation after the 11/17/04 incident, however the RCP and nurse aide assignment lacked evidence that the intervention was initiated. Review of the facility's policy on close observation directed staff to keep the resident in direct eye contact at all times.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(H) and or (o) Medical Records (2)(I).

9. Based on review of the clinical record review, facility documentation and interviews, for 1 of 6 sampled residents (Resident #35) who received anticoagulant therapy, the facility

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failed to ensure that physician orders were obtained in accordance with professional standards to prevent a significant medication error and/or had policies to reflect the role and responsibility of licensed practical nurses with relation to the need for Registered Nurse supervision prior to the implementation of new and/or revised physician orders. The findings included:

a. Resident #35 was admitted to the facility on 1/15/05 with diagnosis that included Atrial Fibrillation (A-Fib). Review of the medical record identified physician's orders dated 1/15/05 for the anticoagulant, Coumadin, three milligram (mg) every day. Review of the medical record and physician order sheets dated 1/15/05 through 1/25/05 identified that R #35's attending physician, MD #1, monitored the resident's anticoagulant status with orders that included intermittent blood work (Prothrombin Time (PT) and International Normalized Ratio (INR)) and changes in the dosage of Coumadin in accordance with assessments of the results of the blood work. Review of R #35's blood work dated 1/25/05 at 9:50 AM identified that R #35's PT was 35.5 (normal 11.7-13.3) and the INR was reported as 8.3 (Normal high dose therapy 3.0-4.5). Review of the medical record identified written telephone orders dated 1/25/05 at 10:00 AM that directed that administration of Coumadin ten mg orally "now," to hold the evening Coumadin, and to recheck R #35"s PT/INR in the morning. The order was written and documented as received by MD #1 by Licensed Practical Nurse #1 (LPN #1). Review of the medical record identified that LPN #1 administered Coumadin 10 mg to R #35 at 10:00 AM on 1/25/05. On 1/26/05, R #35's blood levels were reported as significantly more elevated with a PT of 44.8 and an INR of 13.3. The physician was notified, directed that R #35 receive ten mg of Vitamin K, and be placed on one to one monitoring for the potential for serious bleeding problems. Review of the medical record identified that R #35 received an additional ten mg of Vitamin K on 1/27/05 due to continued super therapeutic blood values, that the resident's Coumadin was withheld for three days, and was resumed on 1/29/05 after the physician determined that a safe, therapeutic range of anticoagulation had been established. Interview with LPN #1 on 3/18/05 at 1:25 PM identified that after the incident, she realized that she had misunderstood MD #1's telephone orders. LPN #1 stated that MD #1 instructed her to give "10 mg of K" and that she understood the physician to say, "10 mg (of Coumadin) okay?" LPN #1 stated that although she read back the telephone order to MD #1, she read it back to him as "give 10 mg now, hold the Coumadin tonight,

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and get a PT/INR in the morning." LPN #1 stated that she was not familiar with therapeutic ranges of a PT/INR but that she did not pursue additional direction from the RN Supervisor. Section 20-87a of the Nurse Practice Act, directs the practice of nursing by a Licensed Practical Nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a Registered nurse or an Advanced Practice Registered Nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(A) and/or (m) Nursing Staff (2)(A).

10. Based on clinical record review, facility documentation and interviews, the facility failed to act promptly to a physician's order for diagnostic testing for one resident (Resident #36) who had a history of congestive heart failure, a history of Digoxin toxicity and who complained of palpitations, and/ or for one sampled resident (Resident #34) who had scheduled medications at 5:00 PM, 6:00 PM and 9:00 PM the facility failed to administer the medications according to the physicians orders and/or for one sampled resident (Resident #29) who had a history of elopement, the facility failed to conduct every fifteen minute checks and/or for one sampled resident (Resident #16) with a history of constipation, the facility failed to ensure daily monitoring of the resident's bowel function. The findings include:
    a. Resident #36 was admitted to the facility on 8/10/04 with diagnoses that included congestive heart failure. Review of the physician's order sheet dated 8/10/04 identified orders for Digoxin 0.125 milligrams (mg.) to be administered every day. Review of the nursing notes dated 12/30/04 identified that R #36 complained to her son in Italian that she was experiencing "palpitations." The documentation identified that R #36's son reported that the resident had a history of Digoxin toxicity. The documentation identified that the resident's physician, MD #2, was notified and ordered a Digoxin level and an Electrocardiogram (EKG). Review of the nursing note dated 12/31 04 identified that the technician arrived to complete the EKG, that the machine was broken, but that he would return later that day. Review of the medical record identified that R #36's EKG was not done until

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1/3/05. In addition, the record identified that the resident's Digoxin level was not drawn until 1/3/05. Review of the 1/3/05 EKG results identified abnormal changes possibly due to myocardial ischemia and a critical Digoxin level of 2.8 (Normal 0.8-2.0). Review of the medical record identified that R #36's Digoxin was held for a day and then restarted at every other day dosing. On 1/7/05, R #36's Digoxin level was 1.9. On 1/10/05, repeat blood work results identified that R #36's potassium level was now 6.3. MD #2 was notified and ordered that two doses of Kayexalate be administered and to transfer R #36 to the hospital for evaluation. Review of the acute care facility's Emergency Department (ED) record identified that blood work utilized to monitor cardiac status was drawn and reported as CK of 147 (Normal 24-173), CK-MB of 69 (Normal 0.0-6.4), and Troponin level of 0.09 (Normal less than 0.03) Review of the interagency referral form dated 1/18/05 identified that R #36 had experienced a myocardial infarction. Interview with MD #2 on 4/26/05, R #36's attending physician at the acute care facility, identified that the 1/3/05 EKG results that identified ischemia could have been related to R #36's high Digoxin level and thus directed the change in Digoxin dosing ordered. MD #2 stated that although the resident's abnormal Digoxin level could have been related to her myocardial infarction, there was no was to be certain without additional diagnostic testing that the family did not wish to pursue at the time.

b. Resident #34's diagnoses include diabetes mellitus, hypertension and Chronic Obstructive Pulmonary Disease (COPD). A quarterly assessment dated 4/5/05 identified that the resident had severe cognitive impairment and required total assistance from staff for activities of daily living. The resident care plan dated 4/20/05 identified potential for complications related to diabetes mellitus, a potential for decreased cardiac output related to hypertension, and an altered breathing pattern related to COPD with interventions to administer medications as ordered. Review of Resident #34's April 2005 medication kardex identified the resident was scheduled to have at 5:00 and 6:00 PM the following medications: Avandia 4 mg, Lisinopril 2.5 mg, Norvasc 5 mg, Singular 10 mg. The scheduled 9:00 PM medications were identified as Super Nu Thera, Metoprolol 50 mg, Pulmicort Respules 0.5 via nebulizer and a fingerstick bloodsugar level at 9:00 PM with Regular Insulin sliding scale coverage. Facility documentation dated 5/3/05 identified an incident on 4 30 05, that Resident #34 had been seated in the D-wing lounge from 6:00 -11:30 PM (5 1 2 hours) without the staff's knowledge of the

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resident's location. The report identified that LPN #5 stated "I've been looking for her all night" and that LPN #5 had not administered the scheduled 5:00 PM, 6:00 PM and 9:00 PM medications. Interview on 5/18/05, at 1:15 PM, with LPN #5 stated she was unable to locate the resident all shift and when the resident was brought to the nurse's station at 11:30 PM is when she administered all of the medications that were due and conducted the fingerstick.

c. Resident #29's diagnoses included arthritis, dementia and a history of alcohol abuse. The admission face sheet dated 9/23/04 identified that Resident #29 was conserved. The admission assessment dated 9/30/04 identified that Resident #29 had memory deficits, moderate cognitive impairment, resisted care and required minimal assistance with ambulating. The Resident Care Plan (RCP) dated 9/24/04 identified decreased functional mobility with an intervention that directed for supervision with ambulating. A care plan revision dated 11/17/04 directed for every fifteen minute checks while the wanderguard was under repair. Review of the fifteen-minute check records from 11/17/04 through 11/21/04 identified that on 11/19/04 the resident's location was observed every fifteen minutes. However, the nurse's note and social service note dated 11/19/04, at 4:00 PM, identified that Resident #29 had left the facility and returned with a six-pack of beer that he had purchased somewhere between 2:15-4:00 PM. The facility was unaware that the resident had left the building. In an interview on 5/12/05, at 12:35 PM, the Assistant Director of Nursing was unable to provide evidence that a thorough investigation had been conducted after the 11/19/04 to determine how the resident was able to leave the facility unnoticed and for more than fifteen minutes.

d. Resident #16's diagnoses included spinal cord injury, gastroesophageal reflux disease, and gastrostomy tube placement with a history of constipation. A significant change assessment dated 12/10/04 identified that Resident #16 was in a vegetative state, required total assistance from staff for activities of daily living and was incontinent of bowel. The Resident Care Plan dated 12/23/04 identified a high risk for constipation. Interventions included to monitor bowel movements and record daily. Nurse's note dated 3/7/05 identified that Resident #16's abdomen was distended, bowel sounds were absent and treatment orders were obtained. Subsequent to a decline, an elevated temperature of 102 degrees, the resident was transferred to the hospital and admitted with abdominal distention. Review of the bowel monitoring record with the Unit Manager on 5/10/05, at 3:00 PM, identified

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that from 2/17/05 through 3/7/05, 18 out of 33 shifts lacked documentation that Resident #16's bowel function had been monitored.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

11. Based on clinical record review, observations and interviews for 2 of 9 sampled residents (Resident #s 10 and 25) who had a physician's order for physical therapy treatment and/or sustained an injury that was possibly related to transfers, the facility failed to failed to ensure that the residents received physical therapy services and/or screen for therapy. The findings include:
    a. Resident #10's diagnoses included open reduction of the left hip, osteoporosis and dementia. A quarterly assessment dated 2/9/05 identified that Resident #10 had memory deficits, moderate cognitive impairment, limited range of motion of one lower extremity and non- ambulatory. The admission orders dated 10/29/04 directed for the physical therapy evaluation and treatment with touch down weight bearing on the left side. Readmission orders dated 11/30/04 directed to continue non-weight bearing status. In an interview on 5/10/05, at 2:00 PM, Resident #10's responsible party stated that the resident had not been receiving physical therapy since November 2004. In an interview on 5/11/05, at 1:30 PM, the physical therapist stated that Resident #10 was non-weight bearing since admission on 10/29/04. On 5/12/05, at 1:00 PM, the physical therapist and occupational therapist identified that a physical therapy screen was conducted on 4/1/05 to clarify the resident's weight bearing status. They stated that there had been a delay between communication with all parties, (the orthopedic physician, responsible party and nursing); the need to repeat the x-rays and that nursing is responsible for physician notification and x-ray scheduling. In an interview on 5/13/05, at 1:00 PM, the orthopedic surgeon stated that the x-rays requested in late November, early December 2004 were not obtained. The surgeon explained that the normal process would be to obtain x-rays six to eight weeks post-operative to determine weight-bearing status and that it is important to initiate weight bearing as soon as the healing process starts to prevent the increase in osteoarthritis and improper healing. The surgeon indicated that the office records identified that there had been no contact with the facility from November 2004 until 4/1/05, at which time physical

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therapy was initiated at a non-weight bearing status. Review of the clinical record and the staff interviews identified that there was unsuccessful communication between the facility and orthopedic surgeon, the x-rays required repeating, therefore Resident #10's weight bearing status had not been clarified prior to discharge to another facility on 5/10/05. In an interview on 5/18/05 Resident #10's responsibility party stated that the resident was receiving daily physical therapy at the new facility.

b. Resident #25's diagnoses included depression, diabetes mellitus, atrial fibrillation and a history of urinary tract infections. The quarterly assessment dated 2/15/05 identified that Resident #25 had memory deficits, some cognitive impairment with new situations only, required total assistance from staff for all activities of daily living, was incontinent of bowel and bladder, limited range of motion with one arm and a history of falls in the past 31-180 days. Nurse's note dated 5/8/05, at 6:55 AM, identified that Resident #25's left shoulder was painful, swollen, reddened and had decreased range of motion. Further review identified that subsequent to an evaluation at the hospital Resident #25 had sustained a contusion of the left shoulder and a sling was applied. The hospital interagency referral record dated 5/8/05 identified that the injury was possibly a result of transferring to/from bed. The RCP revision dated 5/8/05 directed for gentle transfers and assist of one. Observation on 5/10/05, at 4:30 PM, identified the charge nurse and nurse aide transferred the resident from the wheelchair to the bed via a stand pivot. The staff was noted to place their arms under the resident's underarms and lift via the pant waistband. In an interview on 5/11/05, at 1:30 PM, the Director of Nurses stated that the facility does not have a written policy regarding gait belt utilization and that the nurse aides will utilize the belts upon their own discretion or when directed by physical therapy. In an interview on 5/12/05, at 10:20 AM, the charge nurse stated that Resident #25 has rigid body movements, normally is transferred via stand with contact guard of one and that therapy had been informed on 5/11/05 to screen the resident for transfer status. Review of the clinical record with the charge nurse identified that the last full therapy screen was dated 4/04 and that the most recent screen was conducted regarding a change of the wheelchair and/or cushion. In an interview on 5/17/05, at 10:25 AM, the Director of Physical Therapy and the therapist assigned to Resident #25 identified that the screen was conducted on 5/13/05 (5 days after the injury was noted), inservice was conducted with only the

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7-3 PM primary care nurse aide on 5/16/05 for stand pivot transfer utilizing a gait belt and not to assist under the upper extremities and the resident was discharged from therapy on 5/16/05.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H).

12. Based on clinical record review, observations and staff interview for 2 of 17 sampled residents (Resident #s 8 and 34) who required staff assistance with personal hygiene, the facility failed to provide incontinent care in an appropriate time frame, every two hours. The findings include:
    a. Resident #8's diagnoses included dementia and cerebral vascular accident. An annual assessment dated 4/5/05 identified that Resident #8 had memory deficits, severe cognitive impairment, required total assistance with activities of daily living and was incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 4/11/05 identified the resident's incontinence with an intervention that directed to check and provide care every two hours. Observation of incontinent care on 5/10/05, at 10:45 AM, identified Resident #8 lying in bed on an incontinent pad. Further observation identified a brown ring on the incontinent pad, both the incontinent pad and brief were saturated with urine, the resident had been incontinent of stool and a new open area was observed on the scrotum. In an interview on 5/10/05, at 1:20 PM, the nurse aide stated she had checked the resident at 9:00 AM.
    b. Resident #34's quarterly assessment dated 4/5/05 identified the resident had severe cognitive impairment, required total assistance from staff for all activities of daily living and was incontinent of bowel and bladder. The RCP dated 4/20/05 identified that the resident had a self-care deficit and required total assistance for personal care. The RCP also identified Resident #34 was incontinent of bowel and bladder with an intervention to toilet every two hours. Facility documentation dated 5/3/05 identified an incident on 4/30/05 that nursing staff were unaware of Resident #34's location from 6:00-11:30 PM (5 1/2 hours) and at 11:30 PM the resident was observed to be heavily soiled with urine and feces. Review of Resident #34's activity of daily living flow sheet and positioning schedule for 4/30/05 failed to

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identify care was provided to Resident #34 on the 3:00 PM to 11:00 PM shift. Interview on 5/13/05 at 1:40 PM the 3-11 PM nurse aide, on duty 4/30/05 stated she did not provide Resident #34 with personal care and/or assistance for toileting throughout the shift. She further stated that although she looked in the resident's room and dining room, she did not look for the resident anywhere else.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

13. Based on clinical record review, observations, facility documentation and interviews for 4 of 22 sampled residents (Resident #s 6, 8, 17 and 23) who had an alteration in skin integrity, the facility failed to conduct weekly wound assessments and/or failed to develop a comprehensive care plan and/or utilize pressure reliving devices appropriately to prevent or treat skin breakdown. The findings include:
    a. Resident #6's diagnosis included Parkinson's disease. A quarterly assessment dated 3/24/05 identified that Resident #6 had memory deficits, moderate cognitive impairment, required extensive assistance with bed mobility and transfers, was occasionally incontinent of bowel and bladder and a stage two pressure ulcer. A weekly pressure ulcer tracking form dated the week of 2/28/05 identified a stage two area on Resident #6's left buttock that measured 2.0 X 2.2 cm X 0.5 centimeters (cm) that developed on 2/21/05. Further review of the facility documentation from 2/28/05 through 5/9/05 identified that although there was documentation of the wound, the documentation was incomplete and not maintained within the clinical record. According to the facility policy, weekly wound assessments will be conducted on all existing wounds and documented on the weekly wound assessment record in the clinical record. Interview with the infection control nurse on 5/12/05 at 2:30 PM identified that the weekly documentation of pressure ulcers should include size, stage, color, odor, drainage, signs or symptoms of infection, changes in the wound and if the treatment is working. Interview with the Director of Nurses on 5/13/05 at 10:10 AM identified that weekly wound documentation is expected to be completed and available in the clinical record. Additionally, she was unaware that the documentation was unavailable and or incomplete.

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b. Resident #8's diagnoses included dementia, cerebral vascular accident, dehydration and a history of open areas on the scrotum. An annual assessment dated 4/5/05 identified that Resident #8 required total assistance with activities of daily living. The RCP dated 4/11/05 identified that the resident was incontinent of bowel and bladder. Interventions directed to check for wetness and change as needed and to turn and reposition every two hours. Observation on 5/10/05, at 10:00 AM identified the resident lying in bed uncovered and the incontinent brief indicated incontinence. Observation of incontinent care on 5/10/05, at 10:45 AM, identified the resident lying on a brown stained incontinent pad, the incontinent brief was saturated with urine, soiled with feces and a new open area was noted on the scrotum. In an interview on 5/10/05, at 11:15 AM, the nurse aide identified that she was busy and had only checked the resident at 9:00 AM. In an interview on 5/10/05, at 11:25 AM, the Unit Manager identified that the open areas on the scrotum were new.

c. Resident #17's diagnoses included dementia. A significant change assessment dated 1/23/05 identified that Resident #17 had modified cognitive independence, required total assistance from staff for activities of daily living and daily ulcer care. Observations on 5/9/05 and 5/10/05 identified Resident #17 seated on a pressure-relieving cushion in a wheelchair with a pillow and an incontinent pad on top of the cushion. On 5/10/05 Resident #17 was observed to refuse to eat her lunch due to discomfort while sitting in the wheelchair. In an interview on 5/10/05, at 3:00 PM, the Rehabilitation Director indicated the pillow and/or incontinent pad should not have been on the cushion and subsequently the resident was screened by therapy for appropriate wheelchair positioning.

d. Resident #23 had diagnosis that included dementia and insulin dependent diabetes. A significant change assessment dated 1/21/05 indicated moderate impaired cognition, limited to extensive assistance with activities of daily living, occasional incontinence of bowel and bladder and a history of resolved pressure ulcer. Nurse's note date 3/23/05 identified redness to the coccyx area. The note further indicated that a Duoderm dressing was applied to the area. Further clinical review indicated that on 4/21/05 during the 7-3 PM shift an opened area was noted on Resident #23's right buttock. Clinical review and interview with the Resident Care Plan Coordinator on 5/11/05, at 1:50 PM, failed to provide evidence a plan of care was in place that addressed pressure ulcers. Review of the weekly wound report

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documentation with the Infection Control Nurse on 5/11/05, at 2:00 PM, identified that the open area measured 2.0 X 0.5 X 0.1 cm on 4/27/05. The interview further identified the facility initiated a pressure relieving device for the resident's bed on 4/21/05 after the open area was identified.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

14. Based on clinical record review, observations and staff interviews for 2 of 16 sampled residents (Resident #s 21 and 25) who had a history of urinary tract infections, the facility failed to ensure that incontinent checks and/or care was provided every two hours. The findings include:
    a. Resident #21's diagnoses included dementia and urinary retention. An admission assessment dated 2/15/05 identified that Resident #21 had memory deficits, moderate cognitive impairment, was incontinent of urine, required total assistance with transfers and had a history of urinary tract infections. The Resident Care Plan (RCP) dated 3/2/05 identified incontinence and total dependence on staff for toileting. Interventions directed to check and change every two hours, toilet if dry and perform skin care with each change. Physician's order dated 4/13/05 directed for the administration of Levaquin 250 milligrams daily for six days for treatment of a urinary tract infection. Observation on 5/10/05 from 2:00 PM through 6:35 PM (a total of four and one-half hours) identified Resident #21 seated in a wheelchair without the benefit of incontinent checks and/or care. AT 6:35 PM Resident #21 requested assistance, the resident was assisted to the bathroom and although the resident had voided, the resident had been incontinent of urine. In an interview on 5/10/05, at 6:50 PM, the 3-11 PM nurse aide stated that she does not conduct incontinent checks and/or care but waits for Resident #21 to ask for assistance. In an interview on 5/12/05, at 9:05 AM, the Unit Manager stated that Resident #21 required toileting and/or incontinent care every two hours.
    b. Resident #25's diagnoses included depression, diabetes mellitus, atrial fibrillation and a history of urinary tract infections. The quarterly assessment dated 2/15/05 identified that Resident #25 had memory deficits, some cognitive impairment with new situations only, required total assistance from staff for all activities of daily living and was incontinent of bowel and bladder. The RCP dated 2/16/05 identified

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daily episodes of urinary incontinence with interventions to check and change every two hours, toilet if dry and perform skin care with each change. On 5/10/05 Resident #25 was observed from 2:00 PM through 4:30 PM seated in the wheelchair in her room without the benefit of staff providing repositioning and/or checking for incontinence. The 7-3 PM shift primary nurse aide had stated in an interview at 2:30 PM that Resident #25 had been toileted at 1:30 PM. At 4:30 PM Resident #25 was transferred from the wheelchair into bed and incontinent care was provided, three hours after the last toileting check.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(B).

15. Based on clinical record review, observation and staff interview for 1 of 5 sampled residents (Resident #2) who had a gastrostomy tube (G-tube), the facility failed to ensure that the care plan was followed in regards to the prevention of aspiration. The findings include:
    a. Resident #2's diagnosis included dementia. The Minimum Data Set (MDS) dated 4/13/05 identified the resident had memory deficits, moderate cognitive impairment, required total assistance with personal hygiene, was incontinent of bowel and bladder and utilized a feeding tube. The Resident Care Plan dated 4/26/05 identified a swallowing problem. Interventions directed to maintain aspiration precautions and to elevate the head of the bed. Physician's order dated 5/2005 directed for Glucerna Select at 90 milliliters per hour via G-tube continuously. Observation on 5/9/05, at 1:40 PM, identified that the resident's head of the bed was flat and the G-tube feeding was infusing at 90 milliliters per hour while the nurse aide provided personal care. Interview with the nurse aide on 5/9/05, at 1:40 PM, identified that normally the pump is off while she provides care and she thought that the pump was off. Interview on 5/9/05, at 1:45 PM, the charge nurse identified that the nurse aide informs the nurse when she is ready to provide care and the nurse will shut the feeding pump off prior to lowering the head of the bed.

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

16. Based on tour of the facility and interviews, the facility failed to ensure that the environment was safe and secure from resident's accessing hazardous materials. The findings include:
    a. During a tour of the facility on 5/10/05, at 12:45 PM, the A Wing janitor closest door was observed to have tape over the door latch securing the door in the unlocked position when closed. The janitor closet was found to contain a bottle of liquid bowl and bathroom disinfectant cleaner labeled danger, as well as a spray bottle of liquid comet cleanser with bleach. An interview with the Administrator on 5/10/05, at 1:25 PM, indicated that she was uncertain to why the door was taped.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

17. Based on clinical record review, observations and interviews for 1 of 9 sampled residents (Resident #25) who had a history of falls, the facility failed to ensure that the wheelchair seatbelt control box was on and/or attached to the seatbelt. The findings include:
    a. Resident #25's diagnoses included depression, diabetes mellitus, atrial fibrillation and a history of urinary tract infections. The quarterly assessment dated 2/15/05 identified that Resident #25 had memory deficits, some cognitive impairment with new situations only, required total assistance from staff for all activities of daily living, was incontinent of bowel and bladder, had limited range of motion with one arm and a history of falls in the past 31-180 days. The RCP dated 2/16/05 identified the history of falls. Interventions directed for a clip seat belt while up in the wheelchair and tabs monitor. A care plan revision dated 3/14/05 identified a change of the clip belt. Observation on 5/9/05 from 2:45 to 3:15 PM identified Resident #25 seated in the wheelchair with a clip belt fastened self-propelling in the hallway. An alarm control box attached to the wheelchair handle was noted to be in the off position. In an interview on 5/9/05, at 3:15 PM, the charge nurse (RN #3) identified that the alarm control was off. RN #3 demonstrated by unfastening the clip belt that

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the alarm box was attached to the clip seat belt to alert the staff when the resident opened the belt and might attempt to stand. Observation on 5/10/05 from 2:00 PM to 2:30 PM identified Resident #25 seated in the wheelchair in her room. The clip belt was noted to be fastened, however the control box was noted to be detached from the cord. Observation of the resident's wheelchair and interview on 5/10/05, at 2:30 PM, the primary nurse aide and RN #3 identified that the control box was missing. The nurse aide stated that the box was present at 1:30 PM when the resident was toileted. Subsequent to a search, the control box was located on the floor under the resident's bedside chair, reattached to the cord and the clip belt was checked for proper functioning. Further observation at 3:20 PM identified the chair alarm sounding when Resident #25 had unfastened the clip belt.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

18. Based on clinical record review, facility documentation and staff interviews for 2 of 7 sampled residents (Resident #5 and #36) who experienced a significant weight loss, the facility failed to assess and/or monitor the resident's weight. The findings include:
    a. Resident #36 (R #36) was admitted to the facility on 8/10/04 with diagnoses that included dementia and achalasia that required liquid tube feedings via a Gastrotomy Tube (G-Tube). Review of the admission nursing assessment dated 8/10/04 identified R #36 with dry mucous membranes but lacked documentation of the resident's weight on admission. Review of the nutritional screening dated 8/11/04 identified that R #36's usual body weight was 130 pounds. The documentation identified that R #36 had lost approximately 100 pounds over the previous five years. The dietician suggested that R #36 have a pureed diet with bolus feedings of "Fibersource", two cans every eight hours. In addition, the dietician identified R #36 at risk for weight loss and dehydration with interventions to weigh the resident per facility policy and to monitor for signs of dehydration. On 8/18/04, the dietary notes identified that nursing reported that R #36 was unable to tolerate the two cans of Fibersource and suggested a change to one can every four hours. On 9/1/04, R #36's weight was documented as 135 pounds. Review of the dietary note dated 11/29/04 identified a significant weight loss of eleven pounds (8 %) in thirty days. R #36's weight was documented as 124 pounds on 11/29/04, the resident was

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reweighed on 12/1/04 and weighed 123 pounds. The dietician noted that at the time of the nutritional reassessment, there were no available laboratory results to assess hydration/nutritional status. The dietician recommended increasing free water flushes through the G-Tube, and to obtain blood work to assess the resident's current status. R #36's G-Tube feeding was changed to "Resource 2.0" eight ounces every eight hours. Review of laboratory results dated 11/30/04 identified that R #36's Albumin level was 3.1 (Normal 3.5-5.0), Blood Urea Nitrogen (BUN) was 58 (normal 7-17) and creatinine was 2.3 (Normal 0.7-1.2). Review of the physician order sheet dated 12/1/04 identified orders to discontinue the resident's Resource and to begin "Novasource 2.0" eight ounces every eight hours. Review of review and comparison of the Medication Administration Record (MAR) with the intake and output records and the nursing notes from 12/1/04 through 1/10/05 lacked consistent and/or accurate documentation of total fluid/tube feeding intake, free water flushes as ordered by the physician, and/or intakes of pureed foods/oral liquids. In addition, the record lacked documentation to reflect that R #36's weight was monitored more closely after the resident's identified weight loss. On 1/1/05, R #36's weight was documented as 113 pounds, a ten pound weight loss since the resident was last weighed on 12/1/04. No further evaluations were documented by the dietician until after R #36's hospitalization for dehydration on 1/10/05. Interview with the Dietician on 3/17/05 identified that facility policy would have directed a "reweigh" of any resident with a significant drop in weight identified by R #36's documented weight on 1/1/05 and notification of the dietician if the decrease in weight was confirmed. Review of the record with the dietician lacked documentation that R #36 was reweighed until 1/19/05 (upon return from an acute care hospital admission). Additional interview with the Dietician on 3/17/05 identified that if the dietician had been kept informed of R #36's ongoing issues of diarrhea, weight loss, elevated BUN and creatinine, changes in the type of tube feeding might have been warranted and that fluid needs would have been recalculated based on continuing loose stools. Review of R #36's acute care hospital record identified that R #36's weight was 116 pounds on admission to the hospital, a twelve pound weight loss since 11/29/04 and a nineteen pound weight loss (14.5 %) since admission to the facility on 8/10/04. Although changes in the type of liquid feedings to be administered were made, the medical record lacked documentation to reflect that any further interventions were instituted and/or that

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the physician and/or family were notified. Review of facility policy directed that nursing would notify the dietician, physician, and family of any weight variances of 5 % in one month or 10 % in six months. In addition, the policy directed that the physician would document in the progress notes if weight loss was due to a medical condition and would not resolve. Interview with MD #2 on 4/26/05 identified that MD #2 knew of no underlying disease process to attribute to R #36's weight loss.

b. Resident #5's diagnoses included perforated viscus, sigmoid diverticulitis, malnutrition, dehydration and a colostomy. An admission assessment dated 2/11/05 identified that Resident #5 had memory deficits, moderate cognitive impairment, required limited assistance with eating and weighed 116 pounds (lbs) on admission. Physician's order dated 2/11/05 directed for a puree diet, an admission weight, weekly weights times four weeks and then monthly weights. The Nutritional Screen and Assessment dated 2/12/05 identified that Resident #5 received a puree diet secondary to poor fitting dentures, the weight was stable and skin intact. Recommendations were noted, in part, intake and output monitoring and weekly weights times four weeks then evaluate. The 3/15/05 nutritional note identified that the current weight had not been obtained, Resident #5 had a recent weight loss due to the ill-fitting dentures and the plan was to initiate HiCal supplements 90 cc three times a day, check the current weight and weekly weights times four more weeks. The 3/3/105 note identified that Resident #5's weight was 105 lbs on 3/15/05, an eleven pound weight loss in one month. Further review of the nutritional notes from 3/15/05 through 4/11/05 identified that the weekly weeks still had not been conducted as per the physician's order and/or the dietician's recommendation. In an interview on 5/9/05, at 2:30 PM, the Assistant Director of Nurses identified that the clinical record lacked evidence that Resident #5 had been weighed weekly. In an interview on 5/12/05, at 10:00 AM, the Dietician stated that Resident #5 had not been weighed as per physician's order and/or facility policy, the resident experienced a significant weight loss of approximately ten pounds in four weeks and interventions would have been initiated if the loss was identified earlier than 3/15/05.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and or (m) Nursing Staff (2)(A).

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19. Based on clinical record review, facility documentation and interviews, the facility failed to develop a comprehensive plan of care and/or institute interventions, and/or closely monitor two residents (Resident #s 36 and 60) to prevent dehydration. The findings included:
    a. Resident #36 was admitted to the facility on 8/10/04 and had diagnoses that included dementia with achalasia that required liquid tube feeding via a Gastrotomy Tube (G-Tube) and a history of Congestive hear Failure (CHF). Review of the admission nursing assessment dated 8/10/04 identified R #36 with dry mucous membranes and that the resident had a Foley catheter. Review of the physician's order sheet dated 8/11/04 identified orders for Lasix 40 milligrams (mg), a diuretic, to be administered daily except Sundays. The admission assessment dated 8/17/04 identified that R #36 had episodes of diarrhea. Although a review of the medical record identified a Resident Care Plan (RCP) dated 8/12/04 identified a problem of alteration in nutrition with interventions that included to monitor for signs and symptoms of dehydration, the record lacked a comprehensive plan of care to address the resident's risk for dehydration based on diagnoses, diarrhea, and diuretic use and/or interventions to prevent and/or limit the level of dehydration that the resident might experience. In addition, the record lacked documentation to reflect that R #36 was assessed for dehydration and/or that intake and output that included free water flushes were consistently monitored. Review of facility policy directed that residents who receive enteral nutrition required intake monitoring. The policy directed that a weekly evaluation of the average twenty- four hour intake would be reviewed for adequacy and that an evaluation of skin turgor, condition of mucous membranes, edema, congestion, and hydration status would be completed. On 1/10/05, blood work used to monitor hydration status was ordered for R #36. R #36's Blood Urea Nitrogen (BUN) was 291 (Normal 7-17) and the creatinine was 4.4 (Normal 0.7-1.2). R #36 was transferred to the Emergency Department with "marked dehydration." The acute care hospital documentation identified R #36 as obtunded with diminished skin turgor and that the resident was admitted for further monitoring of Acute Renal Failure (ARF) and urosepsis.
    b. Review of Resident # 60's medical record indicated that the resident had a history of diabetes Mellitus, hypertension and acute renal failure. The resident's care plan (RCP) dated 4 14 05 identified potential for dehydration related to acute renal

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failure and use of diuretics with interventions that included to monitor the resident's urinary output and to monitor skin turgor and mucous membranes. Review of the intake and output flow sheets indicated that the resident's output was not monitored but identified only that the resident used the bathroom. Although the resident's intake was monitored through 4/21/04, the record lacked documentation of the resident's intake from 4/22/05 through 4/24/05. Upon interview on 6/3/05, the resident stated that she had difficulty eating and drinking after she developed a sore throat several days prior to her readmission to the hospital. Nurse's notes of 4/23/05 indicated that the resident was identified as having thrush. Upon interview on 6/3/05, the resident's family member stated that he was extremely concerned about the resident's weak and confused condition on 4/23/05 and on 4/24/05 insisted that the resident be transported to the hospital. Although the acute care medical record identified that the resident was admitted with acute renal failure, a potassium level of 9 meq/L, weakness and confusion in the context of poor oral intake and aggressive use of diuretics and required resuscitation, the resident's medical record lacked an assessment of the resident's complete vital signs including temperature, assessment of the resident's lungs, or an assessment of resident's hydration status including skin turgor, mucous membranes and/or mental status. Upon interview, the Director of Nurses (DNS) indicated that output is not strictly monitored for patients with bathroom privileges unless strict monitoring is indicated. No rationale for discontinuing intake monitoring was identified.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H).

20. Based on clinical record review, facility documentation and interviews for 2 of 9 sampled residents (Resident #s 4 and 11) who received antipsychotic medications, the facility failed to ensure the resident's behaviors were monitored and/or assessed. The findings include:
    a. Resident #4's diagnoses included dementia and anxiety with behavioral disturbances. A significant change assessment dated 2/18/05 identified that the resident had memory deficits, moderate cognitive impairment, socially

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inappropriate behaviors and resisted care. Physician's order dated 4/18/05 directed for the administration of Zyprexa 7. 5 milligrams (mg) every twelve hours and Seroquel 25 mg twice a day. Review of the behavior intervention monthly flow record 4/1/05 through 5/11/05 with the Assistant Director of Nurses on 5/12/05, at 10:00 AM, identified that Resident #4's behaviors were not consistently monitored, the records lacked documentation for 78 out of 123 shifts.

b. Resident #11's diagnoses included dementia and cerebral vascular accident. A quarterly assessment dated 4/19/05 identified that Resident #11 had memory deficits, severe cognitive impairment and behavioral symptoms that included crying, altered sleep cycles and resisted to care. Physician's order dated 5/1/05 directed for behavior monitoring every shift. In an interview on 5/12/05, at 9:30 AM, the Unit Manager identified that although there were sporadic nurse's notes that identified the resident's behavior, the documentation was incomplete and the resident was not assessed every shift.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(H).

21. Based on clinical record review, pharmaceutical documentation, and staff interviews for 1 of 1 sampled resident (Resident #3) who received a medication that was manufactured outside of the United States, the facility failed to ensure that the resident's medication regime was reviewed for irregularities regarding an unfamiliar medication. The findings include:

a. Resident #3's diagnoses included end stage pulmonary fibrosis, pulmonary hypertension, cor pulmonade, tricuspid regurgitation, right ventricular dysfunction and chronic respiratory failure. The admission face sheet identified that Resident #3 had been admitted to the facility on 9/24/04. Review of the Medication Administration Record (MAR) from 9/24/04 through 5/9/05 identified that Resident #3 received the medication Tracleer 125 milligrams twice daily at 11:00 AM and 11:00 PM. from the resident's own supply for the treatment of hypertension. The manufacturer's recommendation identified that patients who receive Trocleer require monthly bloodwork specific to liver function tests to monitor for possible liver damage. The information also identified that elevated levels of liver enzymes would require a dose reduction and bloodwork every two

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weeks. Review of the clinical record, the physician's order sheet and laboratory section, on 5/11/05, at 2:00 PM with the 7-3 PM Nursing Supervisor identified that only one set of liver profile bloodwork was obtained from 9/24/04 through 5/11/05, on 2/21/05. In an interview on 5/10/05, at 11:00 AM, the attending physician indicated that Resident #3 was the first resident under his care who received Tracleer and was unaware of the manufacturer's recommendation for monthly bloodwork.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (5)(A).

22. Based on clinical record review, facility documentation and interviews and interview for 5 of 44 sampled residents (Resident #s 2, 27, 36, 39 and 40) the facility failed to ensure that the attending physician conducted visits in a timely manner. The findings include:
    a. Resident #2's diagnosis included dementia. Review of the clinical record on 5/9/05 identified that between 12/01/04 through 5/8/05 (5 months) there was no evidence that the physician reviewed the residents total program of care including documentation in the progress notes and/or signing and dating all physician orders.
    b. Resident #27's diagnoses included lymphocytic leukemia, diabetes mellitus and chronic hypotension. A quarterly assessment dated 2/21/05 indicated that the resident had moderate cognitive impairment with short-term memory loss. Review of the clinical record identified a physician's order and progress note dated 1/29/05 with a subsequent physician's order and progress note dated 4/29/05 (4 month lapse). An interview with the Director of Nurses on 5/13/05 indicated that the required physician's visits were not conducted because the facility system that was in place at the time was not working. The Director of Nurses identified that she was aware that there was a problem with getting the physicians to be timely regarding visits and that a new system had been implemented in 4/2005 to address the issue.
    c. Resident #36 was admitted to the facility on 8/10/04 and had diagnoses that included dementia with achalasia that required liquid tube feeding via a Gastrotomy Tube (G-Tube) due to difficulty swallowing. Review of the medical record identified that MD #2 completed R #36's history and physical examination on 8 11 04. Review of the medical record identified that from 8/11/04 through 1/10/05, R #36 experienced changes in bowel habits that included diarrhea, weight loss, and

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generalized weakness that required interventions that included diagnostic testing and changes in medication. On 1/10/05, R #36 was transferred to the Emergency Department with "marked dehydration." Review of the acute hospital record identified that at the time of admission to the hospital, R #36 had experienced a two to three week history of increasing somnolence, lethargy, and hypotension. Review of the medical record identified that after his initial examination of R #36 on 8/11/04, MD #2 failed to make any subsequent visits to review R #36's medication regime and/or examine the resident from 8/11/04 through 1/10/05, a total of five months. Review of the monthly physician order sheets for R #36 with the Assistant Director of Nursing (ADNS) on 3/16/05 lacked signatures from a physician to renew medications and other orders for the resident in accordance with facility policy for the same five month time period.

d. Resident #39 (R#39) had diagnosis that included Alzheimer's disease with dysphagia. Review of the clinical record identified that from 7/5/04 through 3/16/05, R #39 experienced respiratory symptoms that required interventions that included a diagnostic chest x-ray and antibiotic therapy. Review of the medical record identified that MD #2 failed to make regular visits to review R #39's medication regime and/or examine the resident from 7/5/04 through 3/16/05, a total of more than eight months. Review of the monthly physician order sheets lacked signatures from a physician to renew medications and other orders for the resident in accordance with facility policy for the same eight month time period.

e. Resident #40 (R #40) had diagnoses that included Mental Retardation, a history of dehydration and hyperkalemia. Review of the medical record identified that from 9/29/04 through 3/16/05, R #40 experienced skin tears, respiratory symptoms, an eye infection, and received outpatient surgical removal of a right cheek squamous cell that required interventions that included dressing changes, medication changes and diagnostic testing. Review of the medical record identified that MD #2 failed to make regular visits to review R #40's medication regime and/or examine the resident from 9/29/04 through 3/16/05, a total of nearly six months. Review of the monthly physician order sheets lacked signatures from a physician to renew medication and other orders for the resident in accordance with facility policy for the same nearly six month time period. Interview with the facility's Medical Director on 3/16/05 identified that anything that another physician was unwilling and or unable to provide should have been brought to his attention as the Medical

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Director. The Medical Director identified that if a physician is involved with the care of a resident, there was a clear expectation that he/she would examine the resident on a regular basis. The Medical Director identified that at the time of the interview, the facility lacked a system to identify when residents were due to be seen by their physicians. The Medical Director stated that if a physician does not meet the requirements of regular visits and/or meet the care needs of the resident, the facility had a responsibility to notify the Medical Director. The Medical Director stated that he was unaware until the time of the interview, that MD #2 had not examined the residents under his care at the facility on a regular basis. Review of facility policy identified that residents would be seen by a physician at least once every thirty days for the first ninety days after admission ands then once every sixty days thereafter if appropriate for the individual resident.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (n) Medical and Professional Services (5)(A).

23. Based on clinical record review, pharmaceutical documentation, and interviews for 1 of 1 sampled resident (Resident #3) who received a medication that was manufactured outside of the United States, the facility failed to ensure that the consulting pharmacist reviewed the medication regimen for irregularities. The findings include:
    a. Resident #3's diagnoses included end stage pulmonary fibrosis, pulmonary hypertension, cor pulmonade, tricuspid regurgitation, right ventricular dysfunction and chronic respiratory failure. The admission face sheet identified that Resident #3 had been admitted to the facility on 9/24/04. Review of the Medication Administration Record (MAR) from 9/24/04 through 5/9/05 identified that Resident #3 received the medication Tracleer 125 milligrams twice daily from the resident's personal supply for the treatment of hypertension. The manufacturer's recommendation identified that patients who receive Trocleer required monthly bloodwork specific to liver function tests to monitor for possible liver damage. The information also identified that elevated levels of liver enzymes would require a dose reduction and bloodwork every two weeks. Review of the physician's order sheet and laboratory section, on 5/11/05, at 2:00 PM with the 7-3 PM Nursing Supervisor, identified that only one set of liver profile bloodwork was obtained on

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2/21/05. In an interview on 5/10/05, at 1:20 PM, the pharmacist identified being unfamiliar with the medication Tracleer and the recommendations.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8v Pharmaceutical Services (b)(2)(B)(i).

24. Based on clinical record review, facility documentation and interviews, for 2 of 44 sampled residents (Resident #s 16 and 36), the facility failed to ensure that pharmacy recommendations were acted upon. The findings include:
    a. Resident #16's diagnoses included severe acid reflux. The quarterly assessment dated 4/3/05 indicated persistent vegetative state, total dependence on staff for assistance with activities of daily living. Physician's order directed for Reglan 10 milligram three times per day via the gastric tube. Review of the pharmacist/physician's communication sheet identified that on 9/22/04 the pharmacist indicated AIMS tests every six months secondary to the Reglan or for the physician to note clinically contraindicated. Further review of the of the communication sheet dated 3/22/05 and 4/19/05 the pharmacist referenced the requirement for an AIMS test to be conducted. Review of the clinical record with the Unit Manager on 5/10/05, at 3:00 PM, identified that the last AIMS test was dated 9/22/04.
    b. Resident #36 was admitted to the facility on 8/10/04 with diagnoses that included CHF. Review of the physician's order sheet dated 8/10/04 identified orders for Digoxin 0.125 milligrams (mg.) to be administered every day. Review of the pharmacist/physician communication sheet dated 8/19/04 identified a recommendation by the pharmacist to monitor the resident's Digoxin level "with the next lab draw." On 10/20/04, the pharmacist again recommended that a Digoxin level be drawn. Subsequent monthly reviews by the pharmacist on 11/14/04 and 12/15/04 again recommended that the resident's Digoxin level be monitored. Interview with the Director of Nursing (DNS) on 4/25/05 identified that facility policy directed that pharmacy recommendations would be faxed to the physician office if the physician was not due to be in the building and that although the physician may not agree with the pharmacist's recommendation and chose not to follow it, that the physician would be expected to respond to the recommendation. The DNS was unable to explain why the recommendation was not addressed.

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Interview with MD #2 on 4/26/05 identified that the physician could not recall if he had received the pharmacist's recommendations by fax from the facility. Review of the medical record lacked documentation to reflect that the facility ensured that multiple recommendations to monitor the resident's Digoxin level was addressed or that the blood work was ordered until R #36 complained of heart palpitations on 12/30/04.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2).

25. Based on tour of the facility and interviews, the facility failed to ensure that current biological products for utilization of occult blood testing had not expired. The findings include:
    a. During a tour of the facility on 5/10/05, at 3:00 PM, biologicals were found to be expired. Observation of the A wing medication room the Assistant Director of Nurses found a bottle of occult blood developer with an expiration date of 2000. Observation of the B wing medication room, occult blood cards with the expiration date of 2002 were found on the medication cart. An interview with the medication nurse on 5/10/05, at 3:35 PM, indicated that card could still be used. Observation of the storage area with the stock room manager on 5/11/05, at 11:00 AM identified that the facility did not have any occult blood testing supplies in storage because they were changing vendor and indicated that the current supply are located on the nursing units.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

26. Based on clinical record review, observations and interviews, for 1 of 6 sampled residents (Resident #38) who required a dressing change and/or for 2 of 11 sampled residents (Resident #2 and #8) who were incontinent of urine the facility failed to maintain appropriate infection control techniques. The findings included:
    a. Resident #2's diagnosis included dementia. The Minimum Data Set (MDS) dated 4 13 05 identified the resident had memory deficits, moderate impaired cognition, required total assistance with toilet use and total incontinence of bowel and bladder.

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The Resident Care Plan dated 4/26/05 identified a self-care deficit related to dementia with the need for total care and directed to provide assistance with hygiene. Observation on 5/9/05, at 1:40 PM, identified that while providing incontinent care the nurse aide placed soiled linen and the soiled incontinent brief on the residents bedside table and after removing the soiled items washed the table top with water only. Interview with the charge nurse on 5/9/05, at 1:45 PM, identified that soiled linen should be placed in a bag, not on the bedside table.

b. Resident #8's diagnoses included dementia. An annual assessment dated 4/5/05 identified that the resident had memory deficits, severe cognitive impairment and required total assistance with activities of daily living. Observation of incontinent care on 5/10/05, at 10:45 AM, identified that after providing incontinent care, the nurse aide placed the washcloth soiled with urine and feces on the overbed table, removed the gloves, opened the privacy curtain, donned new gloves without the benefit of handwashing. In an interview on 5/10/05, at 11:15 AM, the nurse aide identified that she should have disposed of the soiled linen in a plastic bag and washed her hands after removing the gloves.

c. Resident #38 (R #38) had diagnosis that included Alzheimer's disease. Review of the medical record identified that R #38 had developed a 0.25 by 0.25 by 0.5 centimeter (cm.) Stage II open area at the left buttocks. Review of the medical record identified physician's orders for treatment to the area with a duoderm dressing to be changed every three days and on an as needed basis. Observation of R #38's incontinent/wound care on 3/15/05 at 1:25 PM identified that after Nursing Assistant #2 (NA #2) provided R #38 with incontinent care, the duoderm dressing edges were observed to be peeling away. NA #2 removed the dressing from the resident's left buttocks without washing her hands and/or changing her gloves. NA #2 notified LPN #2 that R #38's dressing needed to be replaced. In addition, observation of LPN #2 who provided the dressing change at 1:40 PM identified that the LPN utilized gloves that she removed from her uniform pocket to provide the treatment to R #38's wound. The pocket from which LPN #2 removed the gloves was the pocket that held a set of keys for intrafacility areas such as the medication carts. Interview with Infection Control Nurse (ICN) on 3/17/05 identified that NAs are not expected to remove dressings and should notify the nurse to attend to the resident. The ICN stated that gloves used to provide incontinent care should be changed prior to removal of a dressing. In addition, the ICN stated that the gloves

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utilized to provide care to residents should be pulled from a box and not from a uniform pocket.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (t) Infection Control (2)(A).

27. Based on clinical record review, observations, facility documentation and interviews for 2 of 19 sampled residents (Resident #s 8 and 15) who required incontinent care, the facility failed to conduct appropriate handwashing technique after care was rendered. The findings include:
    a. Resident #8's diagnoses included dementia. An annual assessment dated 4/5/05 identified that the resident had memory deficits, severe cognitive impairment and required total assistance with activities of daily living. Observation of incontinent care on 5/10/05, at 10:45 AM, identified that during incontinent care the nurse aide removed and donned new gloves without the benefit of washing hands in between. Further observation identified that after providing incontinent care, the nurse aide removed the soiled gloves, opened the privacy curtain and donned new gloves without the benefit of handwashing. In an interview on 5/10/05, at 11:15 AM, the nurse aide identified that she should have washed her hands after removing the gloves.
    b. Resident #15's diagnoses included right tongue and tonsillar squamous cell mass, depression, and tracheostomy. A significant change assessment dated 3/21/05 identified that Resident #15 had no cognitive impairment and was independent in activities of daily living. The Resident Care Plan (RCP) dated 4/4/05 identified a potential for complications related to the tracheostomy. Interventions directed to provide tracheostomy care every shift and to use sterile technique. Observation of tracheostomy care conducted by the Director of Respiratory Therapy on 5/11/05, at 2:10 PM, identified that after contact with the tracheostomy appliance, the open area around the stoma and dried secretions on the resident's skin, the therapist was noted to don sterile gloves over the non-sterile contaminated gloves utilized during care. The therapist was observed to insert a sterile inner cannula into the tracheostomy. Review of facility policy on 5/11/05, at 3:15 PM with the Director of Nurses identified that the used gloves should have been removed and handwashing conducted prior to donning a new pair of gloves.

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The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (t) Infection Control (2)(A).

28. Based on clinical record review, facility documentation and staff interviews for one of two sampled residents (Resident #29) who had a history of elopement, the facility failed to ensure that the environment was safe and secure to prevent further occurrences. The findings include:
    a. Resident #29's diagnoses included arthritis, dementia and a history of alcohol abuse. The admission face sheet dated 9/23/04 identified that Resident #29 was conserved. The admission assessment dated 9/30/04 identified that Resident #29 had memory deficits, moderate cognitive impairment, resisted care and required minimal assistance with ambulating. The Resident Care Plan (RCP) dated 9/24/04 identified decreased functional mobility. Interventions directed for supervision with ambulating. Review of facility documentation, nurse's notes and the RCP from 10/26/04 through 11/21/04 identified that Resident #29 had eloped on four occasions. On 10/26/04, during the 3-11 PM shift, Resident #29 was found outside the facility asking for directions and a wanderguard was initiated on the right wrist. On 11/17/04, at 2:10 PM, a nurse aide called the facility to inform staff that Resident #29 was noted walking down a highway that is 0.6 of a mile from the facility, the resident was brought back by the nurse aide and every fifteen-minute checks were initiated while the wanderguard was under repair. On 11/19/04, at 4:00 PM, Resident #29 was found seated in his room with a six-pack of beer, the resident admitted to leaving the facility to purchase the beverage. On 11/21/04, at 10:30 PM the local authorities contacted the facility to inform them that Resident #29 was found on the same highway as on 11/17/04. Review of the facility's investigation lacked documentation that the staff had heard and/or responded to the alarm system on 11/19/04 and 11/21/04. In an interview on 5/12/05, at 12:35 PM, the Assistant Director of Nursing (ADNS) and Director of Maintenance recalled that that several months back the wanderguard system at the main entrance was not functioning properly. The Maintenance Director explained that although a senor alarm system purchased from Radio Shack was installed temporarily, the system was shut off during the visiting hours because the alarm sounded every time the

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door was opened. The ADNS stated that office personnel are located at the main entrance until 9-9:30 PM and upon their departure the sensor alarm was activated. The wanderguard vendor invoice identified that an order was initiated on for 11/23/04 six days after the system was noted to require repair. Although a temporary alarm was installed at the main entrance, the alarm was not heard on the resident units to alert staff that someone exited the building.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (m) Nursing Staff (2)(C).

29. Based on clinical record review, facility documentation, and staff interview the facility failed to provide an orientation program for agency nurses prior to accepting responsibility for resident units. The findings include:
    a. Resident #34's diagnosis included diabetes mellitus, hypertension and chronic obstructive pulmonary disease. Facility documentation dated 5/3/05 identified an incident on 4/30/05 in which Resident #34 spent 5 1/2 hours in a television lounge, the D Wing, without the benefit of care and services. The documentation further identified that when a family member found the resident in the lounge and brought the resident to the nurse's station, the charge nurse (LPN #5) stated "I've been looking for her all night", the nurse had not administered the resident's 5:00 PM, 6:00 PM and 9:00 PM medications and did not conduct did the 9:00 PM finger stick for blood sugar to determine insulin coverage. Interview with LPN #5 on 5/18/05, at 1:15 PM, stated when she came to work at the facility on 4/30/05 the 7-3 PM charge nurse gave her the roster of residents on the unit and reviewed some of the residents with her. LPN #5 explained that the 3-11 PM Nursing Supervisor came onto the unit, introduced herself and stated that if LPN #5 needed anything to call her. LPN #5 explained further that she had asked the Supervisor to wait and the Supervisor remarked that she would be back, however the Supervisor did not return. LPN #5 stated that upon entering the facility no formal orientation was provided to her regarding her duties and responsibilities.
    b. Resident #35 was admitted to the facility on 1/15/05 with diagnosis that included Atrial Fibrillation. Review of the medical record identified physician's orders dated 1 15 05 for the anticoagulant, orders that included intermittent monitoring blood

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work that included Prothrombin Time (PT) and International Normalized Ratio (INR) and changes in the dosage of Coumadin in accordance with assessments of the results of the blood work. Review of R #35's blood work dated 1/25/05, at 9:50 AM, identified that R #35's PT was 35.5 (normal 11.7-13.3) and the INR was 8.3 (Normal high dose therapy 3.0-4.5). Review of the medical record identified handwritten telephone orders dated 1/25/05, at 10:00 AM, that included direction to administration of Coumadin ten mg orally "now." The order was written and documented as received by MD #1 by Licensed Practical Nurse #1 (LPN #1). Review of facility documentation dated 1/26/05 identified that LPN #1 had misunderstood MD #1's telephone order and had inadvertently administered Coumadin 10 mg. instead of what MD #1 had actually ordered, Vitamin K 10 mg (the antidote to an elevated anticoagulant level) to R #35, at 10:00 AM, on 1/25/05. Interview with LPN #1 on 3/18/05, at 1:25 PM, identified that after the incident, she realized that she had misunderstood MD #1's telephone orders. LPN #1 stated that MD #1 instructed her to give "10 mg. of K" and that she understood the physician to say, "10 mg (of Coumadin) okay?" LPN #1 stated that she was not aware that she was only to implement new and/or revised medication orders under the direction of an RN. LPN #1 stated that she was from an outside agency, it was her first time working in the facility, and her brief orientation to the facility did not include direction related to new medication orders. Section 20-87a of the Nurse Practice Act, directs the practice of nursing by a Licensed Practical Nurse defined as the performing of selected tasks and sharing of responsibility under the direction of a Registered nurse or an advanced practice Registered nurse. Review of the facility's orientation and medication policies with the Director of Nursing on 3/16/05 identified that the facility failed to provide clear direction for LPN's who take telephone and/or verbal orders from a physician that included the need for the LPN to seek direction from and/or consultation with an RN prior to implementing the orders.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and or (j) Director of Nurses (2).

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30. Based on clinical record review and staff interview for 5 of 44 sampled residents (Resident #s 6, 9, 22, 30 and 34), the facility failed to ensure that the clinical record contained complete and accurate documentation. The findings include:
    a. Resident #6's diagnosis included Parkinson disease. Review of facility documentation from February through April 2005 identified that the resident had a pressure ulcer on the left buttock and although there was weekly documentation of the wound, the documentation was incomplete and/or not maintained within the clinical record. Interview with the Director of Nurses on 5/13/05, at 10:10 AM, identified that weekly wound documentation is expected to be completed and available in the clinical record. Additionally, she was unaware why the documentation was unavailable and/or incomplete.
    b. Resident #9's diagnoses included cerebral vascular accident. An annual assessment dated 4/30/05 identified that Resident #9 had moderate cognitive impairment and required assistance with all activities of daily living. A skin assessment dated 1/19/05 identified that the resident was a high risk for pressure sores. The May 2005 Treatment Record identified that a treatment to the coccyx. Review of the clinical record failed to identify that weekly wound assessments had been conducted to include wound characteristics, i.e. size, depth, odor, drainage. In an interview on 5/10/05, at 11:15 AM, the Infection Control Nurse (ICN) identified that she maintains the wound tracking sheets in a separate binder in her office. Review of the ICN's tracking sheets failed to provide consistent and complete documentation regarding wound characteristics, i.e. size, depth, drainage, odor and/or date wound was identified.
    c. Resident #22's diagnosis included dementia. The pressure ulcer record dated 1/7/05 identified a pressure ulcer on the resident's right heel that measured 0.4 cm by 0.3 cm. The weekly wound report dated 5/3/05 identified a stage III pressure ulcer on the resident's right heel measuring 1.8 cm by 1.2 cm by 0.1 cm. Review of the clinical record from 1/7/05 through 5/11/05 failed to identify weekly documentation of the resident's right heel pressure ulcer.
    d. Resident #30's diagnosis included diabetes mellitus. An inter-agency referral report dated 2/10/05 identified Resident #30 was found unresponsive in the wheelchair and had a blood sugar level of 40. Glucagon 1ml was administered intramuscular and the blood sugar at 9:15 AM was 119. Review of Resident #30's clinical record on 2/10/05 failed to identify the resident's unresponsive episode and what nursing

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measures had been implemented. In an interview on 5/11/05, at 2:30 PM, the Assistant Director of Nurses stated that although she recalled Resident #30's blood sugar level to be low and Glucagon was administered twice, the clinical record lacked documentation of the hypoglycemic episode.

e. Resident #34's diagnoses include diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. The documentation identified that resident #34 had not received care and services from 6:00 PM to 11:30 PM, (5 1/2 hours). The report indicated that at 11:30 PM Resident #34 received the scheduled 5:00, 6:00 and 9:00 PM medications and the 9:00 PM fingerstick was conducted. In an interview on 5/18/05, at 1:15 PM, LPN #5 stated she did administer Resident #34's medications at approximately 11:15 PM. LPN #5 stated further that she should have documented in the resident's clinical record and Medication Administration Record the exact time the medications were administered, what the blood sugar result was and wrote a nurse's note of the evening's events.

The above are violations of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2) and/or (k) Nurse Supervisor (L)(M).

31. Based on clinical record review for one resident, interview with facility personnel and a review of the resident's acute care medical record, the facility failed to monitor one resident's laboratory values in accordance with physician's orders. The findings include:

    a. Resident # 60 was admitted to the facility on 4/11/05 following for a skin graft to the lower extremity and lithotripsy with placement of a urethral stint. The resident had a history of Diabetes Mellitus and acute renal failure. The resident's care plan (RCP) dated 4/14/05 identified the potential for dehydration related to acute renal failure and use of diuretics. Interventions included to monitor the resident's urinary output and to monitor electrolytes, BUN, and creatinine per physician order and report abnormal laboratory values. The resident's BUN, creatinine and potassium level on 4/9/05 were 20 mg/dL; 1.1 mg/dL; and 3.8 mmol/L, respectively. Although additional laboratory values were ordered by the physician on 4/16/05 to be drawn on 4/18/05, review of the medical record on 6/3/05 failed to identify that the laboratory values were received and reported to the physician. A record of laboratory results collected on 4/18/05 and obtained upon request on 6/3/05

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identified the resident's BUN, creatinine and potassium levels as 85 mg/dL; and 5.6 meq/L, respectively. On 4/24/05 the resident's medical record indicated that the resident was transported to an acute care facility with complaints of back pain, cough and increased respiratory rate with shortness of breath. The acute care medical record identified that the resident was admitted with acute renal failure, a potassium level of 9 meq/L and confusion in the context of poor oral intake and aggressive use of diuretics and required aggressive resuscitation. The Director of Nurses stated that the facility does not have policies or procedures to track ordered laboratory tests.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(H).

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.